

HEARING TO EXAMINE THE IMPLEMENTATION OF WOUNDED WARRIOR POLICIES AND PRO- GRAMS

HEARING
BEFORE THE
SUBCOMMITTEE ON PERSONNEL
OF THE
COMMITTEE ON ARMED SERVICES
UNITED STATES SENATE
ONE HUNDRED ELEVENTH CONGRESS
FIRST SESSION

APRIL 29, 2009

Printed for the use of the Committee on Armed Services



U.S. GOVERNMENT PRINTING OFFICE

54-356 PDF

WASHINGTON : 2010

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON ARMED SERVICES

CARL LEVIN, Michigan, *Chairman*

EDWARD M. KENNEDY, Massachusetts	JOHN MCCAIN, Arizona
ROBERT C. BYRD, West Virginia	JAMES M. INHOFE, Oklahoma
JOSEPH I. LIEBERMAN, Connecticut	JEFF SESSIONS, Alabama
JACK REED, Rhode Island	SAXBY CHAMBLISS, Georgia
DANIEL K. AKAKA, Hawaii	LINDSEY GRAHAM, South Carolina
BILL NELSON, Florida	JOHN THUNE, South Dakota
E. BENJAMIN NELSON, Nebraska	MEL MARTINEZ, Florida
EVAN BAYH, Indiana	ROGER F. WICKER, Mississippi
JIM WEBB, Virginia	RICHARD BURR, North Carolina
CLAIRE McCASKILL, Missouri	DAVID VITTER, Louisiana
MARK UDALL, Colorado	SUSAN M. COLLINS, Maine
KAY R. HAGAN, North Carolina	
MARK BEGICH, Alaska	
ROLAND W. BURRIS, Illinois	

RICHARD D. DEBOBES, *Staff Director*
JOSEPH W. BOWAB, *Republican Staff Director*

SUBCOMMITTEE ON PERSONNEL

E. BENJAMIN NELSON, Nebraska, *Chairman*

EDWARD M. KENNEDY, Massachusetts	LINDSEY GRAHAM, South Carolina
JOSEPH I. LIEBERMAN, Connecticut	SAXBY CHAMBLISS, Georgia
DANIEL K. AKAKA, Hawaii	JOHN THUNE, South Dakota
JIM WEBB, Virginia	MEL MARTINEZ, Florida
CLAIRE McCASKILL, Missouri	ROGER F. WICKER, Mississippi
KAY R. HAGAN, North Carolina	DAVID VITTER, Louisiana
MARK BEGICH, Alaska	SUSAN M. COLLINS, Maine
ROLAND W. BURRIS, Illinois	

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

HEARING TO EXAMINE THE IMPLEMENTATION OF WOUNDED WARRIOR POLICIES AND PROGRAMS

APRIL 29, 2009

	Page
Gadson, LTC Gregory D., USA	5
Noss, Kimberly R., Ph.D.	6
Kinard, 1st Lt. Andrew K., USMC (Ret.)	7
Williamson, Randall B., Director, Health Care, Government Accountability Office; Accompanied by Daniel Berton, Director, Education, Workforce, and Income Security Issues; and Valerie C. Melvin, Director, Human Cap- ital and Management Information Systems Issues	26
McGinn, Gail H., Deputy Under Secretary of Defense for Plans, Department of Defense	54
Embrey, Ellen P., Acting Principal Deputy Assistant Secretary of Defense for Health Affairs	60
Dimsdale, Roger, Executive Director, Department of Veterans Affairs/Depart- ment of Defense Collaboration, Office of Policy and Planning, Department of Veterans Affairs	65
Meurlin, Maj. Gen. Keith W., USAF, Director, Office of Transition Policy and Care Coordination, Department of Defense	70
Timberlake, RADM Gregory A., USN, Director, Interagency Program Office, Department Of Defense/Department Of Veterans Affairs	75
Guice, Karen S., M.D., M.P.P., Executive Director for the Federal Recovery Coordination Program, Department of Veterans Affairs	80

HEARING TO EXAMINE THE IMPLEMENTATION OF WOUNDED WARRIOR POLICIES AND PROGRAMS

WEDNESDAY, APRIL 29, 2009

U.S. SENATE,
SUBCOMMITTEE ON PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:33 p.m. in room SH-216, Hart Senate Office Building, Senator E. Benjamin Nelson (chairman of the subcommittee) presiding.

Committee members present: Senators E. Benjamin Nelson, Hagan, Begich, Graham, Chambliss, Thune, and Wicker.

Committee staff member present: Leah C. Brewer, nominations and hearings clerk.

Majority staff members present: Jonathan D. Clark, counsel; Gabriella Eisen, counsel; and Gerald J. Leeling, counsel.

Minority staff members present: Paul C. Hutton IV, professional staff member; Daniel A. Lerner, professional staff member; Lucian L. Niemeyer, professional staff member; Diana G. Tabler, professional staff member; and Richard F. Walsh, minority counsel.

Staff assistants present: Mary C. Holloway, Jessica L. Kingston, Brian F. Sebold, and Breon N. Wells.

Committee members' assistants present: Ann Premier, assistant to Senator Ben Nelson; Gordon I. Peterson, assistant to Senator Webb; Roger Pena, assistant to Senator Hagan; Clyde A. Taylor IV, assistant to Senator Chambliss; Adam G. Brake, assistant to Senator Graham; Erskine W. Wells III, assistant to Senator Wicker; and Rob Epplin, assistant to Senator Collins.

OPENING STATEMENT OF SENATOR E. BENJAMIN NELSON, CHAIRMAN

Senator BEN NELSON. Good afternoon. The subcommittee meets today to discuss the implementation of wounded warrior programs, policies, and plans by the Department of Defense (DOD) and the Department of Veterans Affairs (VA).

This hearing was originally scheduled for April 1, 2009, but unfortunately, had to be postponed due to a series of stacked votes. I want to thank the members of our second and third panels, who were all present and accounted for, ready to testify, when the hearing was called off at the last minute. We thank you for your patience and understanding.

The delay produced a very positive result. On that same day, April 1, Senator Graham and I were fortunate enough to meet with a group of wounded warriors and some of their family members who candidly shared with us the positive and negative experiences they'd gone through, and are still going through, on their journeys through treatment, the disability evaluation process, and transition to the next chapters of their lives.

During that meeting, Senator Graham and I mentioned the possibility of the group testifying at a hearing on a future date, to which they all graciously agreed. Now, little did they know the day would come so soon. Because of the hearing's postponement, we were able to create a new first panel and we have invited them all to speak about their experiences as seriously wounded servicemembers, veterans, and as spouses of wounded warriors.

We all remember February 18, 2007, the day the first in a series of articles appeared describing problems faced by our wounded warriors receiving care in an outpatient status. Many of these servicemembers, who were wounded or injured in service to our Nation, were living in substandard facilities, were unaccounted for, and were fighting their way through a bungled, adversarial administrative process to rate their disabilities. After they left DOD care, they had to start all over with the VA, and many fell through the cracks in the transition. As a result of these articles and various reports on wounded warrior transition policies and programs, Congress passed the Wounded Warrior Act, which was incorporated into the National Defense Authorization Act (NDAA) for Fiscal Year 2008.

The Wounded Warrior Act, among many other things, required DOD and VA to work jointly to develop and implement a comprehensive set of policies to improve the care, management, and transition of recovering wounded, ill, and injured servicemembers. The Act also required the Comptroller General to assess and report on the progress made by the two departments in this endeavor. This report is near completion, so on our second panel we have personnel from the Government Accountability Office (GAO) to share their findings.

On our third panel, we'll have several representatives from DOD and VA. They will discuss DOD and VA efforts to organize and resource wounded warrior program and policy improvements, as well as the accomplishments to date of the DOD/VA Wounded, Ill, and Injured Senior Oversight Committee (SOC) which has been in place for nearly 2 years and is comprised of several high-level DOD and VA officials. In fact, in a hearing earlier this year, Secretary Gates himself pledged to chair this oversight committee's meetings during this period of administration transition, along with Secretary Shinseki of the VA. This is evidence of the priority placed on helping wounded warriors and their families within the highest echelons of these departments. I'll introduce our DOD and VA witnesses when the third panel convenes.

I'm very pleased to welcome our first panel. These men and women, who represent wounded, Active Duty servicemembers, veterans, and their families, are the reason we're all here today. We have with us Lieutenant Colonel Gregory D. Gadson, United States Army; Lieutenant Colonel Raymond T. Rivas, United States Army;

his wife, Mrs. Colleen O. Rivas; Ms. Kimberly R. Noss, Ph.D., the spouse of a seriously wounded servicemember; and First Lieutenant Andrew K. Kinard, United States Marine Corps.

The wounded warrior legislation passed by Congress required DOD and VA to collaborate on many levels. The departments have been tasked with great challenges, such as jointly developing a fully interoperable electronic health record, improving the disability evaluation system (DES), establishing centers of excellence for psychological health, traumatic brain injury (TBI), and eye and auditory trauma coordinating care, and much more. Collaboration on such a large scale was new ground for these two huge government agencies. The fact that DOD and VA have been able to work so closely on so many different levels is a sign of great commitment on their part to ensuring that our wounded, ill, and injured servicemembers and their families are given the best care management and support possible while navigating through these bureaucratic processes. With any undertaking of this magnitude, there are bound to be outstanding issues and problems to work out along the way.

I visited with many of our wounded warriors, including soldiers from Nebraska, at Walter Reed Army Medical Center (WRAMC). The servicemembers that I've spoken with lauded the treatment they were receiving at WRAMC, and so, I commend the efforts of those who have worked to improve the outpatient care and treatment of our wounded warriors. I also learned, however, of many issues that indicate there's still work to be done.

We've heard of the shortage of healthcare professionals. We owe it to our troops and our country to adequately assess the medical condition of our servicemembers prior to their deployment. I recently learned of incomplete medical assessments, due to a shortage of time or manpower, which, in one case, resulted in the unnecessary exacerbation of a servicemember's medical condition. In another case, the incomplete medical assessment resulted in the deployment of a medically unfit servicemember whose condition quickly deteriorated in Afghanistan, causing him to collapse in the field. This servicemember consequently had to be medically evacuated from the forward deployment for a known medical condition.

When our servicemembers return home with war wounds, it's imperative that we have the medical personnel and resources available to care for them. It's also essential that we make efforts to treat our servicemembers as close to home as possible. The ability to receive care near their home base provides a better network of support for the servicemember, and will likely speed recovery time.

Ensuring we have the means and resources in place for medical assessments and adequate treatment facilities is why oversight hearings such as this are so very important. As we reflect on the work done to date in improving these policies and programs for our servicemembers and their families, we must also identify any existing gaps or problems in the care, coordination, and transition process. Only after we identify problems can we work to find answers and provide the highest quality of care for our wounded, ill, and injured servicemembers and their families.

This is far more than just a procedural issue. The purpose of these massive policy and program reforms is to care for our wounded warriors.

Now it's my pleasure to welcome Senator Graham. We're delighted to have you here with us today to discuss these critical issues, and I ask if you would like to make an opening statement.

Senator Graham, would you like to make an opening statement?

Senator GRAHAM. Very briefly, Mr. Chairman.

STATEMENT OF SENATOR LINDSEY GRAHAM

Senator GRAHAM. I want to thank you for conducting this hearing. You've been a terrific supporter of the Wounded Warrior Program, and men and women in the military, in general. We met with this group. We were going to have a hearing a couple of weeks ago, and we had a bunch of votes scheduled, but the Chairman was kind enough to come to my office, and I think we got a lot out of that meeting with our wounded warriors who are here today, and Andrew Kinard who worked in my office (gesturing), and we learned a lot. One thing I learned is that I don't want these hearings to be taken by anybody as there's a lack of caring—there's not a lack. People care a lot. There's a lot of bureaucracy out there that cares a lot. We've just got to get it focused on doing the best job it can.

Secretary Gates has put \$300 million in the budget, which will help us. It's a budgetary item now for the Wounded Warrior Program, and the purpose of these hearings is to learn how to do it better, and not to question anybody's motives. If the services are not being delivered well, it's not because people don't care, it's because it's just not working right.

For these Warrior Transition Units (WTUs), we hear some disturbing reports that people feel like the odd guy out. Family members feel like the command climate wasn't as responsive as it could be. That disturbs me. I'd just say this, if you're in charge of a WTU, we're going to judge you by how you take care of those who have paid a real heavy price. I hope that problem can be fixed and is not as bad as some people have said it was.

We're here today to learn, and the best way to learn is from people who live it. That's panel one, and the next panel are the people in charge of making sure it works. We're going to be a team. Every American wants us to get this right. This has nothing to do with party politics. This is the one thing that will bring this country together above all else, taking care of the men and women who have been hurt.

Thank you, Mr. Chairman, for having the right tone and attitude about how to do this.

Senator BEN NELSON. Thank you, Senator Graham. You have been steadfast in your support for this program, whether the roles were reversed and you were chairman and I was ranking member, or the current situation, we will continue to make it bipartisan, nonpartisan, because there's nothing partisan about the need for care for our men and women and their families who serve our country in so many different ways.

Now to our first panel. We welcome four frank assessments of the strengths and weaknesses of the systems supporting wounded

warriors and their families, as well as any recommendations that they may have for improvements in the future.

We'll begin by hearing opening statements, followed by some questions. First, Lieutenant Colonel Gadson, if you would please start us off, and then we'll work our way down the table.

STATEMENT OF LTC GREGORY D. GADSON, USA

Colonel GADSON. Chairman Nelson and Senator Graham, distinguished members of this subcommittee, thank you for this opportunity to testify today to share my experiences as a wounded warrior in the Army medical system.

First and foremost, I cannot overstate how impressed I am with the treatment and care I have received since I was wounded, nearly 2 years ago. WRAMC and other Service medical centers have treated unprecedented injuries and trauma, and not only successfully treated those injuries, but enabled those who have been injured to rejoin society and live productive lives. For that, I am truly grateful and humbled by those in the medical community who have dedicated their lives to making us well.

Dealing with severe injury and trauma is not easy. When you consider the myriad of injuries, as well as the unfamiliarity a typical family has in dealing with an injured servicemember, it's easy to understand how difficult a task it is to recover. I can say, from my vantage point, that our medical system is up to the task.

Over the past 23 months, I have seen tremendous improvements in the quality of care for injured servicemen and their families. However, that does not mean that there isn't room for improvement or gaps don't exist in the system.

One such gap that I personally experienced involves support from a nonmedical attendant. Current policy allows nonmedical attendants to be reimbursed for meals and lodging. Nonmedical attendants' roles are to provide assistance to injured servicemembers in activities they cannot do for themselves—i.e., bathing and driving, et cetera. In my case, my wife was reimbursed as a nonmedical attendant while our household was at Fort Riley, KS. However, when we decided to relocate to the local area in proximity to WRAMC, her nonmedical attendant reimbursement was discontinued.

What I want to illustrate to you is that we don't want to put families in a hardship situation when deciding how and who will assist the servicemember who needs assistance. The fact that per diem and lodging are paid to nonmedical attendants shows an inconsistency in rate, essentially paying nonmedical attendants based on location. I believe there should be a set rate for nonmedical attendants, as well as the per diem and lodging. The situation that family members often find themselves in is how to deal with the loss of income while the servicemember recovers. I have personally seen families remain apart while the serviceman recovers, because they cannot afford to remain together. This is a choice families should not be forced to make.

I would like to emphasize the Army's dedication to our wounded warriors. Our purpose here is to see continued improvement.

Thank you for holding this hearing, and thank you for your continued support for warriors. I look forward to your questions.

Senator BEN NELSON. Dr. Noss?

STATEMENT OF KIMBERLY R. NOSS, PH.D.

Dr. NOSS. First of all, I'd like to thank the committee for allowing me to speak today on behalf of my husband, Sergeant First Class Scot Noss, U.S. Army.

Scot was severely injured in Afghanistan in 2007. He suffered a severe brain injury, with damage to his frontal lobes and brain stem. He had two broken ribs, a pelvic fracture, three fractured vertebrae, and broken feet. So, he sustained a very polytraumatic injury. However, the brain injury was the worst, where, 2 years later, he is currently minimally conscious and is 100 percent dependent for daily living activities.

The past 2 years have been very challenging, considering that we, as a country, were not prepared to take care of these severely injured soldiers. Men and women of the Armed Forces are surviving injuries that would not have survived other wars because of the medical technology available in theater and because of our excellent training from the medic, corpsmen, and from the parascuers. However, there is a huge gap between that technology and training available in theater and what is available stateside for continued long-term healthcare and services for our severely wounded warriors.

I come here today representing the minority of injured, the minimally conscious realm of injury, but represent the ones who need the majority of the long-term healthcare for the rest of their life. One issue that needs to be addressed is TRICARE's lack of coverage of cognitive rehabilitative therapies. Those on Active Duty are able to access this care, but are prohibited, once retired, which is why many families fight to stay in Active Duty service. Unfortunately, just recently at the DOD Cognitive Rehabilitation Consensus Conference, DOD commissioned a formal Emergency Care Research Institute, Institute of Technology Assessment on the benefits of cognitive rehabilitation for combat-injured veterans. This report stated that the assessment, in question, found that the available evidence was of insufficient quantity nor quality to reach meaningful evidenced-based conclusion on the efficacy of cognitive rehabilitation for TBI. However, the Defense Center of Excellence (DCoE) of Psychological Health and Traumatic Brain Injury, a center created by this committee, recently issued a white paper supporting cognitive rehabilitation as a well-accepted and usual-customary component of comprehensive rehabilitation for persons with moderate to severe TBI. Unfortunately, for no other reasons, the conclusion of the report stated that, even though cognitive rehabilitation research shows promising results, they are now, at this time, not covering for veteran-status injured soldiers.

If DOD will cover cognitive rehabilitation for Active Duty soldiers, why will they not cover it once he is a veteran? Why is it sound therapy for an Active Duty servicemember, but not a retiree?

While I understand that this committee does not have jurisdiction over disability compensation, it is still important that you understand that compensation for men and women with mild to moderate functional TBI needs to be addressed. These men and women will not have the opportunity to have a career or retirement be-

cause of their limitations from their combat injuries. What will their future entail? These individuals fall short for benefit coverages that will ensure a healthy lifestyle, but they are not employable, because of their injuries.

What about the caregivers of the severely injured soldiers? The mean age of injured soldiers is 22 years old. If this individual requires 24-hours/7-days-a-week care or constant supervision for safety, how can their family, which most likely are in the prime of their career, afford to quit their jobs and forego retirement benefits to take care of their loved one? What about the 18-year-old wife who did not have the opportunity for education and chose to take care of her severely injured husband instead of putting him in a nursing home? This wife will not have means to income, and should be compensated for her caregiving capabilities and services. Nursing homes are not an option for these young men and women coming back from overseas injured.

The collaborative efforts of DOD and VA have been evident; however, there is still much work to be done. For example, it would be very helpful if a Veteran Benefit Administration (VBA) employee was housed in all of the wounded warrior advocacy offices. For example, the United States Special Operations Command (SOCOM) Care Coalition has been my main source of information and advocacy. Due to the classified nature of SOCOM warriors, if the VBA employee was located in their office, the transfer of veteran status would be smoother because of the initial and continual presence from the transition to veteran status.

Finally, I'd like to say that we should not reinvent the wheel. If TBI rehabilitation and care is better in the private sector, that's where our men and women should go. This country alone has 1.5 million brain injuries a year, where the Armed Forces have only sustained 8,000 since 2001. The VA should have an open mind and a higher fee-based budget to provide the necessary care for these individuals, as well as TRICARE stepping up to the plate to provide such services as cognitive rehabilitation. These men and women of the Armed Forces have earned options and deserve the best in continued healthcare services for their entire life.

I would like to say that, even though these have been the negative aspects of our journey, I do thank DOD and the SOCOM Care Coalition. Scot was a proud Army Ranger, and he fought gallantly for his country. I'd also like to thank the VA. They kept my husband alive and have done superb. Thank you.

Senator BEN NELSON. Lieutenant Kinard?

STATEMENT OF 1ST LT. ANDREW K. KINARD, USMC (RET.)

Lieutenant KINARD. Yes, sir. Good afternoon, Chairman Nelson, Senator Graham, and members of the subcommittee.

I'm pleased to appear before you today to discuss my experiences as a warrior in transition. I hope that, by sharing some of these challenges that I've faced, and some of the successes that I've had, that you can gain a collective understanding of the path forward from here. What I'd like to focus on are some common themes that unite a lot of the wounded warriors that are returning home.

I've faced many challenges in the 2½ years of my recovery since being injured in Iraq, first of all let me say that I would not be

here today were it not for the dedication and professionalism of our medical service personnel. Every breath that I take is a testimony to their service. I mean that.

I was injured, like I said, 2½ years ago, and my subsequent medical evaluation and recovery consisted of over 60 surgeries and countless hours of physical therapy, occupational therapy—you name it, I went to just about every service except for gynecology. [Laughter.]

I was an inpatient at WRAMC when the Washington Post broke the stories, and remained there through all the changes that ensued during the fallout. Some of them have been pretty effective, and some of them we have some way to go forward.

If I might just make a quick comment on the GAO study that you will hear about in the next panel, I've had a chance to read that study, and their overall assessment shows that 60 out of 76 of the criteria have been met. My comment to that is, although mathematically that sounds like a pretty good progress report, even the GAO itself admits that they did not actually study the effectiveness of each of those policies that had been met. All they did was check the box that there is a policy that was created; they didn't actually look at "is this working or not?"

What I'd like to talk to you about today is how we can look at some of these policies that have been out there and say: "are they working or are they not? How can we reduce redundancies within the system? How can we streamline things so that the net effect is a decrease in the amount of confusion amongst the wounded veterans and their families?"

The biggest item is case management and care coordination. The need for competent case management at all phases of transition cannot be overstated, but it's especially critical during the rehabilitation and reintegration phases of a person's transition. If you can get the proper care identified, I think you're going to have a very successful chance of a good recovery. When my doctors knew what was going on and when we identified which specialty service I needed to go see, there's no question, I thought the care that I received at WRAMC in Bethesda was excellent. However, the problem arises in an outpatient status, keeping track of the number of case managers alone can be overwhelming. I can count eight different case managers that I had to keep track of at any one time. The burden of responsibility fell on me to make sure that I knew which of my case managers to go to for which problem. In effect, I was left with a handful of business cards. They all said, "Hey, call me if you have any problems." I said, "I don't really know what to ask or not to ask."

I think one of the things that has been a great success has been the creation of the overall care coordination program within DOD and VA. The DOD has a coordination program called the Recovery Care Coordination Program. The VA, on the other hand, has the Federal Recovery Coordination Program (FRCP). What they simply do is bring together all the resources that we have available within the DOD and the VA, and, at a 30,000-level view, say, "How can we coordinate some of these things?" It's a one-stop shop.

My concern is that, while the Recovery Care Coordinators (RCCs) and the Federal Recovery Care Coordinators (FRCCs) are really

doing the same thing, and the only difference is what category of wounded person they're treating, FRCCs typically manage the care of the more seriously injured and more critically injured servicemembers, while RCCs treat the less severely injured. The two systems are administered by two different departments. One's by VA, one's by DOD, and yet, they're supposed to be doing the same thing and bringing the same resources to bear.

At what level are we going to be coordinating these two programs to make sure that we're getting the most effective treatment delivered to the servicemember and that we're reducing redundant programs so we can also make sure we're spending dollars on beans and bullets where we need to, as well as maximizing our dollars spent on wounded warriors?

I'd also like to comment briefly on the DOD DES Pilot Program that was created directly as a response to some of the criticisms raised in the WRAMC coverage by the Washington Post.

In an effort to simplify and streamline the process, before the DES pilot was created, a recovering servicemember would have to be rated, their whole body rated by the DOD, found unfit to continue service, then transferred into the VA, rated again, and then receive disability compensation. The VA would take quite a while, and there would be a many-month gap between receiving that critical compensation. What DOD and VA did was, they streamlined that process by eliminating one of those two medical examinations. At the same time, I think we still need to make sure and follow up that DOD and VA are doing the handoff correctly and effectively. For myself—and I don't want to get into specifics of my case; but, as an example, it took me roughly 9 months for DOD and VA to figure out that my legs were not growing back. There's some efficiencies that I think we can still continue to enjoy and benefit from if we take hard looks and ask the second and third panel of witnesses how we can really make it work for us up here on the first panel.

Thank you, gentlemen and ma'am, for your time, and I appreciate the opportunity to answer your questions.

[The prepared statement of Lieutenant Kinard follows:]

PREPARED STATEMENT BY 1ST LT. ANDREW K. KINARD, USMC (RET.)

Good afternoon, Chairman Nelson, Senator Graham, and members of the committee. I am pleased to appear before you today to discuss my experiences as a warrior in transition. I hope that by sharing with you some of the challenges that I have faced and the successful experiences that I've had, this committee will gain a better understanding of the issues that are common to all recovering servicemembers.

Although I have faced many challenges since I was wounded in Iraq 2½ years ago, let me first say that I wouldn't be here today were it not for the dedication and professionalism of the medical personnel who treated me from the battlefield through surgical centers in Al Asad, Balad, Landstuhl, Bethesda, and Walter Reed. Every breath that I take is a testimony to their service.

I was injured in the Al Anbar Province, Iraq on October 29, 2006. My subsequent medical evacuation and recovery consisted of over 60 surgeries and countless hours of occupational and physical therapy. I was an inpatient at Walter Reed when the Washington Post stories broke and remained there through all of the changes that followed. Some of the changes to the transition system have been very effective and others remain ineffective due to lack of oversight or interagency coordination.

As you have heard from the other witnesses, recovering servicemembers are facing a myriad number of issues at each phase of transition—recovery, rehabilitation, and reintegration. These three phases were formalized by the Department of De-

fense (DOD) in the Directive-Type Memorandum of January 19, 2009 which establishes policy for the Recovery Coordination Program. One caveat is that the three phases cannot be viewed exclusively as a linear progression; it is not uncommon for reintegration to begin prior to the completion of rehabilitation or for a recovering servicemember to require services typically associated with the recovery or rehabilitation phases after reintegration is considered complete. For example, this is the case for many servicemembers who have a Traumatic Brain Injury (TBI). Oftentimes they will have returned to their home communities but require ongoing cognitive therapy. I have tried to capture thematic issues faced by recovering servicemembers at the second two phases of transition: rehabilitation and reintegration.

REHABILITATION

The need for competent care management at all phases of transition cannot be overstated, but it is especially critical during the rehabilitation phase as the recovering servicemember navigates the various outpatient services available. Two programs are now available to assist recovering servicemembers in coordinating their care: the Recovery Care Coordination (RCC) Program and the Federal Recovery Coordinator (FRC) Program. While each of these two programs essentially provide the same service—with very seriously injured servicemembers managed by a FRC and less severely injured servicemembers managed by a RCC—the RCC program is managed by the DOD and the FRC program is managed by the Department of Veterans Affairs (VA). It is essential that Congress not view these two programs as completely unrelated, but rather Congress should ensure interagency coordination as DOD and VA implement these relatively new programs.

Prior to the FRC and RCC programs becoming available, the onus was on the recovering servicemember to keep up with all of the different case managers and their individual responsibilities. When I was at Walter Reed Army Medical Center, I had a medical case manager, a non-medical case manager, a social worker, a medical board case manager, a Physical Evaluation Board Liaison Officer, a Navy-Marine Corps Liaison Officer, a Wounded Warrior Regiment case manager, and a Marine Corps patient administration team. This list of medical support personnel is roughly the same for all recovering servicemembers in its composition and in the confusion it creates among wounded warriors. What became especially problematic before the advent of recovery coordinators was the transfer of a recovering servicemember to a different medical facility. At each transfer, recovering servicemembers commonly started fresh with case managers who had no previous knowledge of medical history for that patient.

The long list of case managers and other support staff that I previously mentioned all fall within the DOD health care system. As servicemembers transition from active to veteran status, most, if not all, of those case managers will be exchanged for new ones in the VA system. Rather than veterans navigate a new health system with no institutional memory of their medical history, a FRC or RCC can ensure a continuity of medical care.

Additionally, the net result of the number of support staff is that there is a broad diffusion of responsibility among case workers, and the recovering servicemember loses confidence in the government's ability to maintain accountability of his care. Each case worker has a specific role in that servicemember's recovery, and the burden of responsibility falls on the servicemember to keep track of which case manager provides each service. The assignment of a FRC or RCC provides the recovering servicemember with a single point of contact for decisions regarding his or her care. The effectiveness of these two programs, however, should not be measured exclusively by the mere presence of a policy statement outlining the program, but rather by continuous assessments by stakeholders in the process and by recovering servicemembers themselves.

REINTEGRATION

Disability Evaluation System Pilot Program

In an effort to simplify and streamline the process by which servicemembers are medically evaluated, retired, and enrolled into the VA, the National Defense Authorization Act for Fiscal Year 2008 authorized the Secretary of Defense to develop a Disability Evaluation System pilot program. For those who are evaluated through the pilot, the advantages are that there is only one medical evaluation instead of two and that the veteran is immediately enrolled in the VA upon retirement. Those who are not a part of the pilot program must be medically evaluated by their Service—with each Service having different medical standards—then retire. Upon retire-

ment, the veteran must then be medically evaluated by the VA and oftentimes wait many months before receiving disability compensation.

Despite the efficiencies gained by a single medical evaluation using a common standard, the process is often delayed because the disability claim jumps back and forth between the DOD and VA. Health records may be shared electronically, but disability claims are still printed out and physically sent through each office responsible for the paperwork.

Additionally, there has been no change in streamlining the case managers responsible for each claim. Each servicemember must keep track of up to five different case managers who each have some part in the claim process. DOD and VA have both retained a case manager for each segment of the pre-pilot process; the pilot should make an effort to reduce the number of case managers to a single case manager responsible for the entire claim process.

EMPLOYMENT

Many have recognized the need for purposeful activity for those assigned to the various wounded programs to promote recovery and prevent disciplinary problems. Fortunately, many local companies and organizations would like to hire wounded/ill/injured servicemembers for internships while they are healing. These internships can provide a sense of purpose and provide work experience that can be helpful if and when the servicemember leaves the military. The DOD operates a program called Operation Warfighter which places injured servicemembers within the National Capitol Region into internships at locally based Federal agencies. This is a successful program but is very limited.

Allowing this program to expand across the country as well as allowing individuals to intern or have temporary assignment at a local, State, or Federal agency or even a private company would provide a significant benefit to those assigned to one of the military Services' wounded warrior units. From my personal experience, I didn't start feeling like my "old self" until I started an internship at the Pentagon working 20–25 hours a week in the time between physical therapy appointments.

SUMMARY

As the next panels of witnesses come up to testify, you know that they are well intentioned and have our best interests at heart. I respectfully request that you keep in mind two questions as you listen to their testimony:

1. How is effectiveness measured in each of the different programs?
2. How do you ensure that programs within each of the military departments and among different Federal agencies are compatible with each other?

The senior leadership in the DOD and the Veterans Administration have done a remarkable job in breaking down institutional barriers in the last 2 years to provide the best access to services and address difficulties with case management. Unfortunately, this level of cooperation has not yet been institutionalized at the end-user level—that of the recovering servicemember—and many issues remain at that level with respect to access to services and case management. Effective oversight of inter-agency coordination is essential as we move forward so that the men and women who have sacrificed so much are best equipped to recover, rehabilitate, and reintegrate as productive members of our society.

Thank you, Senator Nelson and Senator Graham for the invitation to appear before you today. I appreciate the opportunity to be a part of our American process . . . to come before you and present my perspective to an elected body that has the opportunity to make a difference for so many. I look forward to answering any questions you may have.

Senator BEN NELSON. We thank you very much, Lieutenant Kinard.

We've had join us, since we began, Senator Hagan from North Carolina, Senator Begich from Alaska, Senator Chambliss from Georgia, Senator Thune from South Dakota, and Senator Wicker from Mississippi. Why don't we ask if there are any comments that you'd like to make before we turn to questions. [No response.]

I guess we're ready to turn to some questions. We will do 6-minute rounds.

Some of these questions will, in one way or another, be comparable to some of the testimony you've already made. But, perhaps it'll be a little bit different. For example, this one. Where you had care managers, and they were working with you, do you think they were effective in getting you better care?

We'll start with you first, Lieutenant.

Lieutenant KINARD. The question, sir, is were the case managers effective in delivering? Yes and no. I feel that the sheer volume alone of case managers, the number of case managers there are available, creates a diffusion of responsibility within the overall system. Having the RCC program and the FRCP, which are relatively new—what they do is, they bring all those together to one person that I can call and say, "Let's figure this out together." I think that is certainly a great improvement that DOD and VA have made. I can't say, in every single case, that the case managers dropped the ball, but it certainly will make it easier having these programs in place with effective oversight and coordination between the two departments to allow us to achieve the maximum medical benefit.

Senator BEN NELSON. What we did see, though, is, in bringing a case manager in, at least it appears that we got over the hurdle that we had, where people were unaccounted for. Wounded warriors were unaccounted for. At least was it effective in having you accounted for? Did we make any progress there?

Lieutenant KINARD. I think the individual Services have made tremendous efforts in accountability. At the end of the day, just looking at this issue through the lens of your average patient, the 18- to 24-year-old male, he's going to trust that guy in uniform. He's going to go to the sergeant, he's going to go to his noncommissioned officer. I think we've done a tremendous job, and the Services ought to be commended for how they've really stepped up to the plate with case management and with accountability.

Senator BEN NELSON. Thank you. Dr. Noss?

Dr. NOSS. I was very fortunate to have the SOCOM Care Coalition manage—and continue to manage—Scot's care and his Active Duty status, and know that he will be a part of the SOCOM Care Coalition for life. If we're trying to have a system to be modeled by, I really do think it's the Care Coalition. They have done a fabulous job ever since General Brown started the organization.

I have not had any bad experiences when it comes to case management, because of the Care Coalition.

Senator BEN NELSON. Mrs. Rivas?

Mrs. RIVAS. We haven't had any bad experiences, either. The case manager, in fact, saved us. When he first arrived at Brooke Army Medical Center (BAMC), he just sat there in a room, and, at that point, he didn't have a case manager. When they assigned him a case manager, that's when things started moving along. With the TBI, he couldn't remember anything. She coordinated everything and made sure that he got to where he needed to be and that all of his care was taken care of. We had a wonderful experience.

Later on, SOCOM came in, the Care Coalition. At first, they didn't realize he was there; he was kind of in limbo. When they found him, that's when the ball started rolling. They have stayed

with us afterwards and made sure that we are up on any new care issues that arise. They've both been wonderful.

I need to add this, too. The case manager, she was the one that was able to get his outpatient farmed out to the Rehabilitation Institute of San Antonio. It's an institute that helps with mild to severe brain injuries. If it wasn't for that, he wouldn't be where he is today. The outpatient care has been wonderful.

Senator BEN NELSON. Such a simple concept, but an essential part of the tracking and keeping care appropriate and constant so that something doesn't lose its momentum.

Mrs. RIVAS. It's made all the difference in the world to us, to where he is today and to where he was. He couldn't do simple things like get dressed and feed himself, and he stuttered terribly, he couldn't carry on a conversation. They worked with him on every aspect, and he is so much better today. I have to say, we have a wonderful VA vocational counselor that we've been put in touch with, and she got him involved in the Easter Seals program. It's just having that contact.

Senator BEN NELSON. Thank you.

Colonel Gadson?

Colonel GADSON. Yes, sir. I would echo what Lieutenant Andrew Kinard said. The multiple case managers can be a bit confusing, and I personally have raised a question as to why—in fact, in Andrew's case and my case, because we're amputees, we have a specific amputee case manager, and then we have another case manager, and he may even have some additional ones.

I guess the frustration is, where is the accountability? Even to this point, I would say that I don't understand what the clear delineation between responsibility is, and so, there's a potential gap, not that I've had any personal issues with it. You have to be on your game and understand what's going on, and make sure that doesn't happen. I feel like I've been able to, for the most part, advocate for myself. I think there's room to streamline that, and I think they recognize that, but we haven't gotten there yet.

Senator BEN NELSON. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. I thank the panel for sharing your experiences with us.

Make sure I get this right. You get wounded, you get back home, your Active Duty pay continues until you're medically discharged. Is that right?

Colonel GADSON. Correct.

Senator GRAHAM. Now, in terms of support for the spouse who's life has changed as much as yours has, there is a compensation stream, is that right, Colonel Gadson?

Colonel GADSON. Sir, first I'd like to say that they have the Traumatic Servicemembers' Group Life Insurance, which is the traumatic insurance that you get.

Senator GRAHAM. How much is that?

Colonel GADSON. It really depends on your injury. There's no set amount.

Senator GRAHAM. Okay. But, you get a payment.

Colonel GADSON. You get a payment. That can, in some cases, be used to offset that, but I can tell you certain circumstances where people have had to move and they haven't been able to sell their

house, and it starts eating into money that wasn't necessarily designed for that.

Senator GRAHAM. But, my question is, a family member is going to, maybe, have to quit their job—

Colonel GADSON. Yes, sir.

Senator GRAHAM.—or certainly, their life is affected dramatically. What income stream is available to them? Dr. Noss?

Dr. NOSS. Right now, through VA benefits, they have a small portion—it's called aid and attendance—which is to pay for caregiving hours or to be utilized by the family member who's doing the caregiving.

Senator GRAHAM. How much money did that mean for you?

Dr. NOSS. \$580 a month.

Senator GRAHAM. Okay. Andrew, you're not married, I know. Your dad's a doctor, and your mom—are fairly well off, but there are a lot of guys your age that don't have that—what do single guys get?

Lieutenant KINARD. Single guys, with the family members coming to take care of them? I am not familiar with the compensation, sir.

Colonel GADSON. Senator Graham, I believe, right in the Washington, DC, area, the per diem for a caregiver—or nonmedical attendant would have been about \$30 a day.

Senator GRAHAM. Okay. Your concern is, it shouldn't be based on where you're located, it should be a flat rate, where they bump up based on location, right?

Colonel GADSON. Plus per diem, yes, sir.

Senator GRAHAM. Mrs. Rivas, did you get any income support?

Mrs. RIVAS. I'm not aware of any of this. We lived off his retirement pay and savings so this is new information to me.

Senator GRAHAM. All right. That's why we have these hearings.

The point that I'm trying to make is that the country needs to come to grips with the fact that the moment the person is catastrophically, devastatingly injured, the family changes, and I think most Americans would like an income stream available to family members who provide that support that otherwise would be given by the Government. But, the one thing highly unlikely, the Government caretaker's not going to live with you 24-hours-a-day, maybe, like a family, so that's something, Mr. Chairman, I think we can look at, is finding a revenue stream.

Now, Dr. Noss, how old are you?

Dr. NOSS. I'm 28 years old.

Senator GRAHAM. What's your educational background?

Dr. NOSS. I have a doctorate in chemical engineering. I actually just graduated, this past semester.

Senator GRAHAM. How old is your husband?

Dr. NOSS. He's 31. He's an E-7.

Senator GRAHAM. As Andrew said, most of these wounded are young people right?

Dr. NOSS. Yes.

Senator GRAHAM. What have you found, in terms of their spouses' capability or family members' capability to survive these injuries, financially?

Dr. NOSS. Actually, the 2 years that I have been inpatient with my husband, because Scot is still inpatient at the VA in Tampa, a majority of the families are very young. Most of the wives who come with their injured husbands don't have jobs. They were stay-at-home mothers, they are 17-, 18-, 19-year-old high school-educated, young women.

Senator GRAHAM. Andrew, what would you have done if you didn't have the family you have?

Lieutenant KINARD. Sir, I would have been by myself. My dad left his practice for 2 months, came up to Washington, DC, moved up here. My mom lived with me for over 7 months until I was discharged from the hospital and able to take care of myself.

Senator GRAHAM. Colonel Gadson?

Colonel GADSON. Senator, the tough task, as you're saying and alluding to, is that these are young families. I was a senior officer, and I had the revenue to be able to withstand my wife not being at work as a professional schoolteacher. But, even that, that took about a third of our income away from us.

Senator GRAHAM. I think this is something the committee can work on.

You're still on Active Duty is that right, Colonel?

Colonel GADSON. Yes, sir.

Senator GRAHAM. They're going to let you stay on Active Duty, it looks like?

Colonel GADSON. They are.

Senator GRAHAM. I want to congratulate the Service for doing that.

Andrew, I know you're going to Harvard Law School. To those that helped Andrew, look what you've done. He's going to Harvard and has a great life ahead of him.

It took you 9 months to get from one medical evaluation to the other? Tell me about that again. What's the 9 months?

Lieutenant KINARD. Sir, I actually did most of that when I was a congressional fellow in your office.

Senator GRAHAM. Yes, I know. [Laughter.]

You've gone Hollywood on me, now, I see you on TV all the time. [Laughter.]

Lieutenant KINARD. No comment. [Laughter.]

Sir, that was one of the big issues that was highlighted. The inadequacies with the flexibility and the speed.

Senator GRAHAM. You were medically discharged from the Marine Corps about a month ago, is that right?

Lieutenant KINARD. That's right.

Senator GRAHAM. Now, you're 100 percent disabled by VA?

Lieutenant KINARD. Yes, sir.

Senator GRAHAM. What took 9 months to figure out that your legs weren't going to grow back? Tell me what you mean by that.

Lieutenant KINARD. There were actually two different boards that I went through. There's the Medical Evaluation Board (MEB), which is the DOD evaluation of your fitness to continue service in the military in the job in which you were assigned, or they can find you another job. Then, once they determine that you are no longer fit to continue serving, they refer you over to VA to a Physical Evaluation Board (PEB) that rates the amount of compensation

you are owed for your injuries. It's going from that one board, where they have to prepare all the materials, hand it to the next board; if there's anything wrong, it gets sent back. Then, that other board sits on it and they——

Senator GRAHAM. Is that still the case today?

Lieutenant KINARD. It is. I hate to say that every case is 9 months, but I think I fell within about an average period of time for the DES.

Senator GRAHAM. Thank you.

Colonel RIVAS. Senator, if I can make a comment?

Senator BEN NELSON. Yes.

Colonel RIVAS. My situation is a little different from the other individuals here. I was retired at 100 percent from the military, 100 percent from VA. I was a civilian engineer with DOD, with the Army. I was medically retired from that, at a significantly reduced income. I was a licensed law enforcement police officer in the State of Texas, was retired from that, with no retirement income. So, we've seen significantly reduced income from my retirement. The issue I have is with the concurrent receipt law, the way it's currently written. Even though I had 35 years of military service, both Active and Reserve, I lose all my VA to get my military retirement. I think that's a real injustice, because if I had 20 years, the way the law is written, I would receive both of those. I didn't choose to get blown up before I made sure I had 20 years of Active Duty, so I could get both of those. We have to wait until I'm age 60.

Senator GRAHAM. You were injured when you were a Guard member or a Reserve——

Colonel RIVAS. Reserve. Since then, I've come down with some secondary issues with kidney failure and some other issues. My family's concern is I may not live long enough to see my concurrent receipt.

Senator GRAHAM. Thank you.

Senator BEN NELSON. We've been working on that program, making some improvements, but we still have a long way to go to get that fair and equitable. Thank you.

Senator Hagan.

Senator HAGAN. Thank you, Mr. Chairman.

First, I want to thank each and every one of you for all of your service, and the wives, you, too, are to be complimented for all of your extended care that you've been giving.

Dr. NOSS, I have question for you. Your husband is currently—I think you said, is in Tampa; he's still in care.

Dr. NOSS. Yes. He is still an inpatient at the Tampa VA, the Polytrauma Unit.

Senator HAGAN. Will he leave? Will he be sent someplace else? What's his long-term prognosis, as far as where he might go?

Dr. NOSS. He's going home with me.

Senator HAGAN. He'll be able to come home?

Dr. NOSS. We're going to make it where he can come home. I don't believe in putting him in a nursing facility for long term.

Senator HAGAN. Then, from the standpoint of any sort of financial help to you at that point in time, what has VA established for that?

Dr. NOSS. They do have a benefit package that Scot will receive every month, and it is a substantial amount of money. However, the net income will be small because you have to take into consideration our bills that we will incur each month. For example, I know of a family who has a quadriplegic and he's on a ventilator. Because of needing a 24-hour power source, their power bill is over \$1,000 a month. This is due to the ventilator, and his bed—he has to have a special type of bed that's hooked up to power. Because of the special care that Scot is going to receive because of his injuries, we're going to have to pay for large bills. Despite the substantial amount of benefit money that will come in per month, the net is going to be small.

Senator HAGAN. You mentioned one other comment. I believe it was the cognitive rehabilitative therapy, that if—as long as he was considered active military, he would receive that, but then, once he became veteran status, it was not funded.

Dr. NOSS. Yes, ma'am, that's correct.

Senator HAGAN. Is he currently getting that?

Dr. NOSS. Yes, he is receiving cognitive therapy at the VA, at the Polytrauma Unit, which I have to say is absolutely fabulous. I just love them down there. However, my concern is if we need to take him to a private-sector rehabilitation center. TRICARE, as it is stated right now, will not pull from the supplemental fund that they have set aside for Active Duty soldiers to pay for cognitive rehab for veteran status.

Senator HAGAN. I see.

Dr. NOSS. So, right now they are not covered for cognitive rehab.

Senator HAGAN. It feels like we ought to be doing something about that, too.

Dr. NOSS. Right. I really hope you can.

Senator HAGAN. Lieutenant Colonel Rivas, I hear, all the time, your concern on the concurrent receipt issues. That's something I'm glad to hear Senator Nelson say we've been working on for a long time, but it seems like we certainly need to be moving forward, because it doesn't make a lot of sense to me at all.

Thank you, Mr. Chairman.

Senator BEN NELSON. Thank you, Senator.

Senator THUNE.

Senator THUNE. Thank you, Mr. Chairman.

Let me also add my deep appreciation to all of you for your great service to our country and the sacrifices that you and your families have made. We are, as a Nation, enormously grateful. Please know how much we appreciate that.

In his prepared testimony, Major General Meurlin outlined several improvements that DOD and VA have made to DES through the pilot program. He also says that more should be done and we need to “shift away from a focus on pay entitlements to one of recovery, rehabilitation, transition, and making the servicemember a viable member of society.”

I guess what I would ask any member of the panel to answer is, in your opinion, what steps can DOD or VA and this committee take to improve the system and focus more on recovery, rehab, and transition?

Colonel?

Colonel GADSON. Yes, sir. I have a few suggestions.

The first is—and I know we're working toward that—is getting VA and DOD together at the highest levels. The Army—I was fortunate enough to have the Army to send me to graduate school, and I'm finishing up my graduate degree at Georgetown now, while I am recovering. But to illustrate this, in terms of VA benefits, there are some VA benefits that I don't have access to unless I retire. By staying on Active Duty, I'm only authorized a one-time \$11,000 vehicle grant, because I lost my legs, and that's to get a new vehicle and modify that vehicle. Then there is a \$60,000 housing grant—again, for the modification of an existing home or to apply toward a home. Other than those two benefits, I cannot access my education benefits for vocational rehabilitation. For instance, my daughter is a junior in high school, and I will not be able to use any of my veteran's benefits toward her college, which I would be able to do if I were to retire.

I think we need to take a comprehensive look at those benefits, and merge that. Those benefits were built under the assumption that, when a servicemember was severely injured, he was going to be out. As we look at our force, as an All-Volunteer Force, many people still opt to continue to serve, or would like to continue to serve, and they should be allowed to have access to a benefit. This is not a benefit to double any kind of compensation or get something that you're not authorized, but just giving you access to it when you need to. I think that's a discussion or a dialogue that needs to take place as we look at these two things holistically.

Senator THUNE. Good.

Dr. Noss?

Dr. NOSS. About the rehabilitation for minimally conscious patients, I really do think that integration into a civilian-sector rehab would benefit these men and women greatly. There are four polytrauma centers in the country right now, a fifth one being built in San Antonio. There's one located in Tampa, where I'm located now, which I'm so grateful that the Fisher House was built on its campus. I have been staying at the Fisher House for a year and a half now. There's one in Richmond, Minnesota, and Palo Alto.

Now you're having an issue of families relocating from their strong support systems and from their family in order to be close to the polytrauma center. That shouldn't be an issue. The family should be able to relocate to their desired location and have some sort of rehabilitation in the private sector.

My husband is still Active Duty, and I'm fighting to keep him Active Duty. It's not about the money. I've been hearing for 2 years now, "Now, Mrs. Noss, if you retire him, you'll be getting more money every month." I don't care about the money. What I'm caring about is the fact that when he retires, he will lose some of his coverage for his therapies. I am really fighting to keep him in. I'm so appreciative of DOD for actually understanding my reasons for wanting to keep him Active Duty, and they've been very helpful.

For the cases, as my husband, the minimally conscious patients that are still Active Duty and have retired since, really need to work on how we can better improve the health care after veteran status is achieved.

Senator THUNE. Anybody else?

Lieutenant KINARD. Senator Thune, very briefly, if we're shifting away from a focus on pay and entitlements, where are we shifting to? I think the word is reintegration. Becoming productive members of our society is essential. Picking back up, getting back up on our feet, moving forward. We got injured, but, hey, we still have value and we can be productive. I think we need to take a look at some of the employment opportunities available while service-members are recovering in the WTUs.

There's a program here in the National Capital region called Operational Warfighter. I think it's a fantastic program. It allows guys at WRAMC and Bethesda to go intern in any of the Federal agencies in the Washington, DC, area. The downside is, it's only in the Washington, DC, area, that I know of. If you're at Fort Bragg, if you're at BAMC, if you're at any of the other medical military treatment facilities, I don't know what programs are available to get guys into some sort of internship, especially for the ones that know that they're going to be transitioning out of the Service.

In a way, as the old saying goes, "Idle hands make for the devil's work." Having gainful employment, in whatever capacity, even looking at perhaps doing something within the private sector for those that are in more remote locations and don't have Federal or State agencies right there, I think that could be a great step forward towards reintegration.

Dr. NOSS. May I add one more thing, as well? With the integration to society for the mild to moderate brain-injured who fall beneath the realm of the benefits to compensate a healthy lifestyle, the employment rate is drastically lower because of their combat injury. For example, I have befriended a family whose son was in an improvised explosive device blast in 2003. Because of his injuries, he is not able to have a very high-stress job. He is able to work produce at a grocery store, and that's a very healthy transition into society for him. He feels a part of the society again, he doesn't feel like he's lost any type of integrity, and he's really proud of that job.

Helping these mild to moderate brain-injured men and women be able to find something to help them become productive citizens is very important for them for long-term recovery.

Mrs. RIVAS. I'd like to add something to that, too. Our VA counselor got us involved with the Easter Seals program, and they've been working with Ray on a daily basis on cognitive skills and job skills and job training. Outsourcing to the Easter Seals and other programs like that have been a big help.

Senator THUNE. Mr. Chairman, I appreciate very much the perspective offered here, and I hope that we can use the insights as we shape policies to deal with these very important issues. Thank you.

Thank you all very much for being here today and for your testimony.

Senator BEN NELSON. Thank you.

Senator BEGICH.

Senator BEGICH. Thank you very much, Mr. Chairman. Thank you for holding this hearing.

Thank you all for your testimony, I have learned a great deal listening. It sounds like you have also learned something about a pro-

gram that exists, which I think is part of the process of this hearing.

I just want to make sure I understand how that works and how the nonmedical attendants receive pay or don't receive pay. I want to make sure I understand that clearly. Who can walk through that with me?

Lieutenant Colonel Gadson?

Colonel GADSON. Yes, sir.

Senator BEGICH. If you can walk me from the point of when the injury occurs. What next?

Colonel GADSON. Okay. A soldier is injured, and typically they will remain in a hospital, in an inpatient status, until their medical condition gets to a point where they can transfer or transition to an outpatient status. In the case of these—

Senator BEGICH. I'm sorry to interrupt you—both of these facilities, so far, are all military-operated facilities.

Colonel GADSON. I can't speak for anything outside of WRAMC, but typically WRAMC and BAMC and Palo Alto, out in California, have them—and Bethesda—have the most severely injured.

Senator BEGICH. Okay.

Colonel GADSON. The nonmedical attendant is typically tied to that. We have TBI, and there are some other situations wherein—when a soldier is in an outpatient status, but they cannot perform all the things that they need to do. I couldn't drive, I couldn't get in and out of a vehicle, I couldn't wash without assistance. My wife became that attendant for me, she became that person that did those things for me, and she had to quit her job. We had to relocate our family to this area, and she was no longer working.

Senator BEGICH. Can I interrupt you for a second? So, during that process, she did receive, or did not receive—

Colonel GADSON. When my house was at Fort Riley, KS, which is where I was stationed when I got hurt, she received nonmedical attendant—

Senator BEGICH. Because she was at the location—

Colonel GADSON. She was there with me.

Senator BEGICH. Understood.

Colonel GADSON. Then, when we moved here to consolidate our family, it stopped, because she was in the local area. It really doesn't make any sense. Another way of describing the situation would be, if I were stationed in this local area, and I was stationed at Fort Belvoir and gotten hurt, and the exact same thing happened to me, she would have never received nonmedical attendant.

Senator BEGICH. Oh, really?

Colonel GADSON. Right. Because she's in the local area. The rule or regulation or policy doesn't—it doesn't—

Senator BEGICH. Doesn't make sense.

Colonel GADSON.—doesn't make sense. Then, my point is it pays lodging and per diem for the local area, so someone in San Antonio probably gets paid less than Washington, DC, because of the difference in the—

Senator BEGICH. Sure, the housing costs.

Colonel GADSON.—the cost of living. That was why my recommendation was there should be a flat rate, regardless of wher-

ever it's taking place. Then, of course, you cover the per diem and lodging also.

Senator BEGICH. Anyone else want to add to that?

Dr. Noss?

Dr. NOSS. The transition from your acute military facility, post-injury, to your acute rehabilitation facility—I'm going to have to use myself as the experience. When Scot was injured, he was taken to Bethesda, and we were there for 8 weeks, and then we transitioned to the VA in Tampa. The nonmedical attendee status remained with me, and still is, in Tampa. I'll tell you what, we earn that money whenever we are receiving that nonmedical attendee, because it is very hard. Being a caregiver to a 100 percent dependent loved one is the hardest thing I ever had thought or imagined doing. But, I love him very much, and that's why I do it. But, that nonmedical attendee pay will be drastically reduced whenever he is veteran status. It actually goes away. What everyone continues to tell me is that, "Well, his benefits will counteract the nonmedical attendee's pay, and you will receive more." I think people forget that, because of Scot's status, I had to file for guardianship for him. Now I have to account for every cent that I pay for his benefit from his benefit money. When I have no income coming in, because I'm his 100 percent caregiver, I also have to have accountability for every cent that's spent out of his benefit money. It's going to be very stressful. I know I'm not the only family out there that this is happening to, and it especially is worse when a soldier's parents receive guardianship of him. They are watched like a hawk with his—their money. It is very unfair, in some circumstances.

Senator BEGICH. Thank you.

Colonel GADSON. Senator, I failed to mention—and the Doctor reminded me—and my wife would say this if she were here—that is now a person that is no longer productive in society. My wife was a full-time teacher. She was working, being productive, and she's no longer working and being productive, working toward a retirement, and all those other things. It's really kind of a double whammy, in terms of, your ability to produce. I'm not advocating that the Government should cover all of that. But, you have to understand the scope is not just someone quitting their job and being compensated, but they're no longer producing money towards the household and retirement and all those other kinds of things.

Senator BEGICH. Thank you very much.

My time has expired, but I want to say, again, thank you very much. I'm actually very familiar with this from the Medicaid end. I have a nephew that has spina bifida, and he's now in his late 20s, and I clearly understand the nonmedical attendant and what that means, and the stress that does to the family, and the cost, and the economic costs. Again, I thank you for being here. The information is very helpful, and it's helped me think of some ways that maybe we, as a committee—subcommittee, can move forward. Thank you very much.

Senator BEN NELSON. Thank you, Senator.

Senator Chambliss.

Senator CHAMBLISS. Thank you very much, Mr. Chairman.

Let me thank our witnesses for really excellent testimony. Thank you for your frankness, too.

I want to particularly say to you spouses how much we appreciate you. Commitment to the military is a family commitment, we understand that. We just thank you for your service, in addition to the service of your spouses.

Andrew, I know, as a marine lieutenant, you have to feel like you're still in combat every day you work for Graham. I'm sorry you have to put up with him like you do Senator—[Laughter.]

I just have one question, and it goes to exactly what you were talking about, Andrew, with respect to the coordination of all of these services that you receive. We have a unique situation down in Augusta that I hope I can stick around and talk to the next couple of panels on with respect to the Eisenhower Medical Hospital and the VA and the Medical College of Georgia, all of which are participating in care for our wounded warriors. Case management is a key aspect of what they're doing there. I noted with interest what you talked about. You have all these business cards, and you didn't know who to call, although you knew they were all going to help you, but trying to figure out who you need for the particular service.

I want you to talk a little bit more about that, as to how that is working today, versus how it was 2 years ago, a year ago, or whatever, when you had somewhat of a state of confusion as to who you should call. If anybody else has any experience in that same regard, I wish you'd comment on that.

Andrew?

Lieutenant KINARD. Yes, sir. Interestingly enough, the one single point of contact that I have is based out of Eisenhower in Augusta. Because I'm from South Carolina, she's the closest point of contact to me.

She is what's known as a Federal Recovery Coordinator (FRC), and this program was created in response to some legislation that was passed in title 16 of the National Defense Authorization Act for Fiscal Year 2008, 2 years ago. I'd say that my experience with her has been very positive. I was referred into this program, just in January of this year, after struggling through—and, Senator Nelson, part of what I was talking with Senator Graham about, the 9 months that it took them to evaluate me—I had reached some walls there. I called her on the phone. I was referred to the program. Literally the next day, she had options e-mailed to me, that said, "If you want to do it this way, we can do this; if you want to do it this way, we do that." I said, "I'll take option B." She took care of it, it was done. I said, "Wow, this, for the first time, feels great," knowing that there's somebody I can call that I can hold their feet to the fire, saying, "Why isn't this done?" or "Let's get some answers here."

A couple concerns of mine are how the FRC program is coordinated with the RCC program. I don't have any suggestions for that. I just merely want to highlight that perhaps that merits some taking a looking at.

Also, the FRC program, which was designed to take care of the very seriously injured servicemembers, do they have the right authorities that they need? Do they have enough authority to take

care of the problems? Senator Nelson, I appreciate what you said in your opening statement, sir, and, as Senator Graham echoed, as well—that nobody is arguing here about what servicemembers deserve: the best of the best that our Nation can provide. I applaud you for that recognition. The question is, how do we provide that best of the best? I think the FRC program is a great start.

Dr. Guice, from whom you will hear on the second or third panel, is the program director of this FRC program. She'll be testifying here today. I recommend you ask her some questions about how she feels about the authorities that have been provided to her, if they can meet the needs of the servicemembers.

Senator CHAMBLISS. Yes.

Dr. NOSS. I'd like to also make another comment. I know throughout this whole hearing you've heard Care Coalition, Care Coalition the whole entire time, coming from me and the Rivas, as well. The Care Coalition is the advocacy group from SOCOM. As Andrew was talking about the many business cards that he received, he did not know who to call first. From day one, the SOCOM Care Coalition was my one point of contact. They have been able to organize my life when I was not able to organize my life. They were able to itemize the pros and cons of staying Active Duty versus retirement. They have been there the whole entire way and have made my life easier. I can honestly say that I have never been told "no" by the SOCOM Care Coalition. I've been told "maybe" a couple of times on some little sticky issues, but I really do feel like they have been able to take me from the most traumatic day of my life and carry me through to where I was able to graduate with my dissertation and my Ph.D. I do credit them for doing that for me.

That one point of contact has always been there for me from day one, and that was from the SOCOM Care Coalition.

Senator CHAMBLISS. Okay.

Mrs. RIVAS. It's the same for us with the SOCOM Care Coalition. Then we have VA, too. But, it's the SOCOM Care Coalition that has helped us the most.

Lieutenant KINARD. Senator Chambliss, if I might jump in here and bring one point.

Senator CHAMBLISS. Sure.

Lieutenant KINARD. The SOCOM Care Coalition is a separate entity in the same scheme as each of the Services have their own service-oriented and service-specific WTU. Army has the Army Wounded Warrior Program. Marine Corps has the Wounded Warrior Regiment. SOCOM has their own. When they show up to WRAMC, the Special Forces guys, they just disappear, and they're taken care of. From these two witnesses here, they've received the highest marks, I think, out of the any service-specific transition units.

However, what a concern of mine is, is the net effect when we have DOD-mandated programs and then we have each of the Service-specific programs. If you're in the Navy, you have a different one than the Army or your Marine Corps associates. Where are these being coordinated? Who's taking care of making sure that we're eliminating redundancies so that the net effect is felt by the families who get lost.

Dr. NOSS. I also would like to make a comment. Even though Scot is being taken care of by the SOCOM Care Coalition, his Wounded Warrior project manager from the Army is involved in his care as an Active Duty and as a veteran status. They actually work hand in hand at the SOCOM Care Coalition office. So, I do credit the Army as well for taking really good care of my husband.

Senator CHAMBLISS. Thank you.

Colonel GADSON. Senator, just one last comment. It has improved greatly over the last 2 years. I think DOD is working toward making it more efficient. There is definitely room for improvement. I think all of us would echo this sentiment, that there are a whole lot of folks that are out there trying to do the right thing and trying to do some good. Sometimes they're just stepping on each other. When you put that in light of dealing with these traumatic and difficult times, a lot of times it gets drowned out, and it's too much for folks to manage. I would say that probably SOCOM Care Coalition again, does it the best; and that's generically, regardless of the Service. They're smaller, in a much tighter community, and so I think that's why they're more efficient.

Senator CHAMBLISS. Thank you very much, all of you, for your excellent testimony today. Thanks, Mr. Chairman.

Senator BEN NELSON. Thank you, Senator.

I, too, want to add my thanks for your willingness to come and tell us, as you've seen it and experienced it, and are continuing to experience it. We want you to know that we're very interested, not only in what you have to say, but in finding solutions to the areas that need further work. You can be sure that we're going to do everything we can to try to plug those holes and make it work the way Americans want it to work for our men and women and their families who serve our country in so many important ways.

Thank you, and may God bless you all. Thank you.

Let's give them a round of applause, shall we? [Applause.]

[The prepared statements of Colonel and Mrs. Rivas follow:]

PREPARED STATEMENT BY LTC RAYMOND T. RIVAS, USA (RET.)

I was medically retired from the U.S. Army in September 2008 after being injured in Iraq in October 2006. When I retired, I had completed 14 years of Active Duty and 20 years of Reserve Duty and served on multiple Operation Enduring Freedom and Operation Iraqi Freedom deployments since September 11.

When I was originally injured in October 2006 in Iraq, I was Medivac'd out of theater and sent to the Landstuhl Regional Medical Center in Germany for evaluation. My memory is extremely vague about this. I was told that I spent 7 days there and convinced the neurological staff that I was fit to return to duty. I returned to Iraq, of which I do not remember any of this, and spent approximately 10 days there. I was allowed to go out on missions to forward operating bases, and on mission convoys. It was then reported to my chain of command that my behavior was extremely "bizarre" and I was referred to the Air Force Expeditionary Hospital neurologist. After being examined by him, the orthopedic staff, eye specialist and hearing specialist it was determined that I had a traumatic brain injury, eye injury, moderate to severe hearing loss, and a fractured right patella (knee). I was put on priority Medivac to Landstuhl Regional Medical Center enroute to Brooke Army Medical Center (BAMC). I do not remember any of this, and have referred to my records for this information. Based on my records, the Chief of Neurology at the Balad Field Expeditionary Hospital informed my Command that I did a "very good sales job" of talking myself back to Iraq to rejoin my unit and should have been sent stateside immediately.

In route from Iraq to Germany I had several "unresponsive" episodes during flight. What I do remember about my first few months at BAMC was that the system was "overwhelmed" with the influx of new patients. I was pretty much on my

own for 2–3 months. I had a couple of “battle-buddies” who helped me with dressing, bathing, and eating, as I was not able to do any of these unassisted.

I believe it was approximately 3 months after being there that I began to work with my case manager, Ella Stiles. She immediately began to make things happen in a positive way for my health care. About this same time, I was contacted by the U.S. Army Special Operations BAMC Liaison, Sergeant First Class Craig Coker, who informed me that he had just found out I was one of his Special Operations Officers that the “ball” really began to “roll”.

Once he got involved, I began to get the care I needed for my aforementioned injuries. As mentioned I was medically retired from the Army at 100 percent in September 2008 and am now enrolled full time at the Easter Seals Hospital Brain Injury program in San Antonio, TX, where I continue to participate in their Cognitive Rehabilitation Therapy program.

There are some things that I think must be changed: The Traumatic Servicemember Group Life Insurance Program (TSGLI) expanded this past year to include traumatic brain injury (TBI). While implementing these new changes, the Government Accountability Office contacted my wife and asked to use my medical records in developing the criteria for moderate/severe TBI.

When the changes were implemented, the CARE Coalition which is part of the Special Operations Command submitted my TSGLI Insurance Claim packet. I met the requirements for the maximum insurance reimbursement amount of \$100,000; however, I was only awarded partial payment with no explanation of why. I am currently awaiting word on my appeal that has been submitted by the CARE Coalition. This program is not user friendly, if the injured servicemember meets the requirements for a particular payment amount, he should get it. I feel this is looked at as a game of “lets”-only give minimal amounts and make the servicemember file an appeal, and then we will give a little more, and if a final appeal is filed we will give some more.

Second, I have great “heart-burn” over the concurrent receipt law as now written. As the law now stands, only a servicemember with 20 active duty years is allowed to get both his/her military and VA pension simultaneously.

A Chapter 61 (Medical) Retiree with less than 20 active duty years is not eligible for concurrent receipt; a Chapter 61 National Guard or reservist with a “20 year” letter is eligible, once they turn age 60. This is a clear case of bias and injustice. The servicemember, and Guardsman or reservist who is injured in combat in a theater of operations who was wounded by no fault of his own should not be penalized for “getting blown-up” or “shot” prior to serving 20 active duty years. I had served my country for over 34 years and did not choose to be seriously injured in Iraq in 2006.

This injury has not only ended my military career, but also my civilian career as an engineer with the Department of Defense for whom I worked for 18 years and as a licensed peace officer in the State of Texas where I served as a Reserve Sheriff's Deputy for 8 years with the Comal County Sheriff's Department. I hope this committee is instrumental in doing the right thing in helping make the appropriate changes to the concurrent receipt law to include those such as myself who received combat injuries and forced to retire prior to serving 20 years of active duty.

I would also like to give accolades to the Disabled Sports USA program who has been sponsoring me to participate in Adaptive Sports these past few months throughout the United States the past few months, and the Department of Veterans Affairs, Frank Tejeda Outpatient Clinic, Vocational Rehabilitation Counselor who got me enrolled in the Easter Seals Program.

PREPARED STATEMENT BY MRS. COLLEEN O. RIVAS

I am Colleen Rivas, the wife of LTC Raymond T. Rivas (Retired). I would like to share my views and experiences of the past few years as well as discuss the challenges that lie ahead for my family as we deal with the traumatic brain injury (TBI) that my husband received 2½ years ago in Iraq.

One of the issues that I feel very strongly about is the comparison being made between TBI and post-traumatic stress disorder (PTSD). In my opinion there are profound differences between these two injuries. TBI is a physical trauma that can range from mild to severe. PTSD is an emotional trauma which can have debilitating effects. I have dealt firsthand with both of these traumas where Raymond is concerned; PTSD more so after Afghanistan which was in the form of nightmares and some depression. What we could not deal with on our own he was able to obtain help with through the VA in the form of counseling. The TBI has been an entirely different matter. When Raymond first returned to the U.S. he was sent to Brooke

Army Medical Center. He suffered from severe headaches that painkillers and brain blocks had no affect on. In addition to the headaches, he had trouble with his balance, his depth perception, his speech, his eye to hand coordination, his memory, which included both his long-term and short-term and any task that involved sequencing. He was unable to go anywhere by himself because he was constantly getting lost. It took a year for him to regain his balance and depth perception. Now, 2½ years later, he still suffers from daily headaches, however their severity has lessened. He has regained most of his long-term memory; however he still has trouble with his short-term memory which includes misplacing items on a daily basis and constant repetition of subjects previously discussed. In addition, he cannot follow a detailed set of instructions nor can he multi-task. His condition is frustrating for both him and our family.

Another issue that I feel very strongly about is the transition of the soldier from the battlefield back to civilian life. One thing that I have noticed over the years with Raymond's numerous deployments is the difficulty of transitioning back to everyday life and the stresses that go along with family and work. In my opinion, some sort of decompression time needs to be built in to "time served" so that soldiers can get readjusted to civilian life. I feel like reservists especially have it hard because their deployments are longer and when they are released from active duty, they go right back into their civilian jobs. Some injuries such as mild TBI as well as PTSD may not be apparent until months later. In addition to an assessment as soon as the soldier returns home, some type of reassessment should be done several months later. It is after the soldier returns home and the honeymoon period is over that a lot of the problems begin. Furthermore, if any type of combat action was seen then counseling should be mandatory for the soldier and the family. Soldiers need to understand that their families will never fully understand what they have been through because the family member will never have that experience, and families need to understand that the soldier they sent off to war may not be the same soldier that they get back. For our family, the worst adjustment period was after Afghanistan. Raymond saw a lot of action due to the fact that he was stationed at a Special Forces Fire Base and when he returned from active duty he went straight back into a stressful job and a house full of teenagers. The stress of trying to readjust to civilian life almost destroyed our entire family. I strongly feel that mandatory counseling for him and our family would have made the transition much easier.

It has been a long 2½ years with a lot of ups and downs. Based on reports from military and VA nuerologists some type of long-term care will be needed in the next 5 years. Fortunately, we are working with many good private as well as government organizations that can help us with what lies ahead.

Senator BEN NELSON. The second panel is comprised of GAO subject-matter experts: Randall B. Williamson, who is the Director for Health Care, we welcome you; Valerie C. Melvin, Director for Human Capital and Management Information Systems Issues, we welcome you; and Daniel Bertoni, Director of Education, Workforce, and Income Security, we welcome you.

We look forward to hearing your assessment of the progress made by the departments, thus far, as well as identification of areas where work remains to be done. You've had the benefit of hearing some of our servicemembers and family members express their concerns, as well as their experiences.

With that in mind, Mr. Williamson, we'll ask you if you have an opening statement.

STATEMENT OF RANDALL B. WILLIAMSON, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; ACCOMPANIED BY DANIEL BERTONI, DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY ISSUES; AND VALERIE C. MELVIN, DIRECTOR, HUMAN CAPITAL AND MANAGEMENT INFORMATION SYSTEMS ISSUES

Mr. WILLIAMSON. Thank you, Mr. Chairman, and members of the subcommittee. We are pleased to be here today to discuss actions

that VA and DOD are taking to transition our Nation's recovering servicemembers back to Active Duty or to a veteran status.

Beyond adjusting to their injuries, recovering servicemembers may face additional challenges, including difficulties managing their outpatient recovery process, navigating the military's DES, and transitioning between care provided by DOD and VA.

Our testimony today will discuss the progress made by DOD and VA to jointly develop policies on improvement to the care, management, and transition of recovering servicemembers, as mandated by the NDAA for Fiscal Year 2008. We'll also address challenges both agencies face as they develop and implement policies on these issues.

With me today are Dan Bertoni, a director overseeing our work on DOD and VA DESs, and Valerie Melvin, a director who heads up our work on issues related to information sharing and DOD and VA health records. NDAA for Fiscal Year 2008 required DOD and VA to jointly develop and implement comprehensive policies in four areas: care and management, medical and disability evaluation, return of servicemembers to Active Duty, and the transition of the recovering servicemembers from DOD to VA.

Within these 4 areas, we identified 76 individual requirements contained in the NDAA for Fiscal Year 2008. DOD and VA are addressing these areas and requirements through its Wounded, Ill, and Injured SOC, which was established in May 2007 as a vehicle for jointly addressing issues for recovering servicemembers. It is staffed with both DOD and VA employees.

Overall, DOD and VA have made good progress in developing policies spelled out in NDAA for Fiscal Year 2008. They have completed joint policy development for 60 of the 76 requirements. The remaining 16 requirements are in progress, and VA and DOD officials expect to complete policy development for these requirements by midyear.

In developing policies to address NDAA for Fiscal Year 2008 requirements, DOD and VA have faced numerous challenges, and will continue to do so as they further develop policies and oversee policy implementation.

For example, improving the DES for recovering servicemembers poses a major challenge. Numerous studies have highlighted long delays and confusion that ill or injured servicemembers face as they navigate the military DES.

To help remedy these problems, VA and DOD initiated a DES Pilot Program as a test for consolidating the two departments' DESs. Both agencies have indicated that decisions on the feasibility of consolidating their disability systems will be made after the pilot project is completed.

Possible expansion of this pilot is currently being considered. However, from our perspective, it is unclear what specific criteria DOD and VA will use to evaluate the pilot and whether they will have complete information needed for this evaluation.

Another daunting challenge involved DOD and VA efforts to share electronic health records, an effort that has been underway for over a decade. While the departments are making progress towards increased information sharing, they face further challenges in managing initiatives required to achieve this goal.

GAO has recently reported that the two departments' plans to further increase their electronic sharing capabilities do not consistently identify results-oriented performance measures to accurately assess progress toward the delivery of that capability, nor have the departments completed all necessary activities to fully set up their Interagency Program Office (IPO), including hiring a permanent director and deputy director. Until these challenges are fully addressed, the departments and their stakeholders may lack the comprehensive understanding they need to effectively manage their progress toward achieving increased sharing of information between the departments.

Finally, recent staff changes and working relationships within the SOC could also pose a future challenge. Since January, the SOC has experienced turnover in leadership and changes in policy development responsibilities. Also, DOD established two new organizations as a means to establish a permanent structure to support the SOC.

Some DOD officials consider the changes to be positive developments that will enhance the SOC's effectiveness. In contrast, others are concerned with issues related to communication and interaction among SOC members. Given the recent organizational changes that have occurred in support of the SOC, how this plays out in the future is unknown.

Mr. Chairman, this concludes my remarks. We'll be happy to answer any questions you have.

[The prepared statement of Mr. Williamson follows:]

PREPARED STATEMENT BY RANDALL B. WILLIAMSON

Mr. Chairman and members of the subcommittee: We are pleased to be here today as you examine issues related to meeting the critical needs of recovering servicemembers by reviewing the progress made by the Department of Defense (DOD) and the Department of Veterans Affairs (VA) in jointly developing policies mandated by the National Defense Authorization Act for Fiscal Year 2008 (NDAA 2008).¹

Over 1.6 million U.S. troops have deployed in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) since October 2001.^{2,3} In February 2009, DOD reported that over 33,000 servicemembers have been wounded in action since the onset of these conflicts.⁴ Because of improved battlefield medicine, those who might have died in past conflicts are now surviving, many with multiple serious injuries such as amputations, traumatic brain injury (TBI), and post-traumatic stress disorder (PTSD). Beyond adjusting to their injuries, recovering servicemembers may face additional challenges, including difficulties managing their outpatient recovery process, difficulties navigating the military's disability evaluation system, and problems transitioning between care provided by DOD and care provided by VA.

Questions were raised in the media and by Congress about whether DOD and VA are prepared to meet the needs of the increasing number of recovering servicemembers and veterans. In February 2007, a series of Washington Post articles disclosed deficiencies in the provision of outpatient services at Walter Reed Army Medical Center, including poor living conditions at Walter Reed, a confusing disability evaluation system, and servicemembers remaining in outpatient status for

¹ Pub. L. No. 110-181, 122 Stat. 3.

² Terri Tanielian and Lisa H. Jaycox, *Invisible Wounds of War, Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corporation, 2008).

³ OEF, which began in October 2001, supports combat operations in Afghanistan and other locations, and OIF, which began in March 2003, supports combat operations in Iraq and other locations.

⁴ Department of Defense, Operation Iraqi Freedom (OIF) U.S. Casualty Status, Operation Enduring Freedom (OEF) U.S. Casualty Status. www.defenselink.mil/news/casualty.pdf. (accessed Feb. 19, 2009).

months and sometimes years without a clear understanding about their plan of care or the future of their military service. Various review groups investigated the challenges that DOD and VA faced in providing care to recovering servicemembers and made a number of recommendations to address the problems they identified. Shortly after the media disclosures, we testified about the challenges facing recovering servicemembers during their recovery process.⁵

In May 2007, DOD and VA established the Wounded, Ill, and Injured Senior Oversight Committee (SOC) to address the problems that had been identified with the care of recovering servicemembers. The committee is co-chaired by the Deputy Secretaries of DOD and VA and includes military Service Secretaries and other high-ranking officials within both departments. One of the SOC's primary responsibilities is to oversee the development of policies in response to the recommendations of the review groups that studied the issues associated with recovering servicemembers' health care and benefits. Generally, senior officials from the SOC sign and issue interim policy guidance, which is then vetted through DOD's and VA's internal processes to be finalized as department policies.

The NDAA 2008, which was enacted in January 2008, requires DOD and VA, to the extent feasible, to jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering servicemembers. Specifically, section 1611(a) of the NDAA 2008 directs DOD and VA to cover four key areas: (1) care and management, (2) medical evaluation and disability evaluation, (3) the return of servicemembers to active duty, and (4) the transition of recovering servicemembers from DOD to VA. Because of the related ongoing work of the SOC, it assumed responsibility for addressing these requirements. The NDAA 2008 also requires GAO to report on the progress DOD and VA make in developing and implementing the comprehensive policy.⁶ Our work is focused on the status of the development of the comprehensive policy, which includes the development of multiple policies that are further enumerated in sections 1611 through 1614 of the law.

In my testimony today, I will discuss our preliminary findings on: (1) the progress DOD and VA have made in jointly developing comprehensive policies for recovering servicemembers in the areas of care and management, medical and disability evaluation, return to active duty, and transition from care and services received from DOD to VA as required by sections 1611 through 1614 of the NDAA 2008; and (2) the challenges DOD and VA are encountering in the joint development and initial implementation of these policies.

To assess the extent to which DOD and VA have made progress in developing the required policies, we asked SOC representatives to report on the status of policy development for the 76 individual requirements that we identified in sections 1611 through 1614 of the NDAA 2008, which we grouped into 14 categories.⁷ (See app. I for a summary of these requirements and categories.) We also asked the SOC representatives to provide documentation to substantiate the status of each requirement, and we verified the reported status of each requirement by reviewing this documentation. We determined whether each of the requirements (1) had been completed, (2) was in progress, or (3) had not been acted upon. We considered a requirement to have been "completed" if a document had been signed and approved by DOD, VA, or both, at the SOC level, that contained standards, guidelines, or procedures that addressed the requirement, even if DOD, VA, or both plan to issue additional policies on the subject.⁸ We considered a requirement to be "in progress" if documentation demonstrated that work had been initiated to develop standards, guidelines, or procedures that addressed the requirement. We considered a requirement not to have been acted upon if no action had been taken to develop standards, guidelines, or procedures that address the requirement. We based our review in part on the interim policy documents signed by DOD and VA officials working through the SOC. In some cases, interim policy documents were signed by officials of both departments, and in other cases, the documents were signed by officials of one department, depending upon the requirement. Interim policy documents could be in the form of memoranda of agreement, memoranda of understanding, directives, decision- or directive-type memoranda, instructions or policy memoranda, or other

⁵ GAO, DOD, and VA Health Care: Challenges Encountered by Injured Servicemembers during Their Recovery Process, GAO-07-589T (Washington, DC: Mar. 5, 2007) and DOD and VA Health Care: Challenges Encountered by Injured Servicemembers during Their Recovery Process, GAO-07-606T (Washington, DC: Mar. 8, 2007).

⁶ Pub. L. No. 110-181, § 1615(d), 122 Stat. 3, 447.

⁷ We defined an individual requirement as a provision within sections 1611 through 1614 related to the policy required by 1611(a) that directs DOD, VA, or both to take a specific action or to include a specific criterion in their policy. The SOC's legal counsel reviewed these requirements and our groupings, and agreed with our approach.

⁸ Completed policy guidance also included interim policy guidance signed by the SOC.

guidelines or forms of guidance. In addition, we conducted follow-up interviews with DOD and VA officials when we needed clarification on the reported progress or additional documentation. We did not, however, evaluate the quality of the policy documents we reviewed. To identify the challenges DOD and VA encountered in jointly developing and initially implementing the required policies, we interviewed officials from both departments to obtain an account of their experiences in the policy development process. In conducting our work, we interviewed the acting Under Secretary of Defense for Personnel and Readiness, the Executive Director and Chief of Staff of the SOC, the departmental co-leads for most of the SOC work groups, the acting Director of DOD's Office of Transition Policy and Care Coordination, and other relevant DOD and VA officials. We shared the information contained in this statement with DOD and VA officials, and they agreed with the information we presented.

We conducted our work from May 2008 through April 2009 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions.

BACKGROUND

Over the past 8 years, DOD has designated over 33,000 servicemembers involved in OEF and OIF as wounded in action. The severity of injuries can result in a lengthy process for a patient to either return to duty or to transition to veteran status. The most seriously injured servicemembers from these conflicts usually receive care at Walter Reed Army Medical Center or the National Naval Medical Center.⁹ According to DOD officials, once they are stabilized and discharged from the hospital, servicemembers may relocate closer to their homes or military bases and be treated as outpatients by the closest military or VA facility.

Recovering servicemembers potentially navigate two different disability evaluation systems that serve different purposes. DOD's system serves a personnel management purpose by identifying servicemembers who are no longer medically fit for duty. If a servicemember is found unfit because of medical conditions incurred in the line of duty, the servicemember is assigned a disability rating and can be discharged from duty. This disability rating, along with years of service and other factors, determines subsequent disability and health care benefits from DOD. Under VA's system, disability ratings help determine the level of disability compensation a veteran receives and priority status for enrollment for health care benefits. To determine eligibility for disability compensation, VA evaluates all claimed medical conditions, whether they were evaluated previously by the military service's evaluation process or not. If VA finds that a veteran has one or more service-connected disabilities that together result in a final rating of at least 10 percent,¹⁰ VA will pay monthly compensation and the veteran will be eligible to receive medical care from VA.

Efforts to Address the Care and Benefits for Recovering Servicemembers

Efforts have been taken to address the deficiencies reported at Walter Reed related to the care provided and transitioning of recovering servicemembers. After the press reports about Walter Reed, several high level review groups were established to study the care and benefits provided to recovering servicemembers by DOD and VA. The studies produced from all of these groups, released from April 2007 through June 2008, contained over 400 recommendations covering a broad range of topics, including case management, disability evaluation systems, data sharing between the departments, and the need to better understand and diagnose TBI and PTSD.¹¹

⁹These servicemembers may also receive care at Balboa Naval Hospital in San Diego, CA, or at Brooke Army Medical Center in San Antonio, TX.

¹⁰VA determines the degree to which veterans are disabled in 10 percent increments on a scale of 0 to 100 percent.

¹¹The reports are as follows: Independent Review Group, *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* (April 2007); Task Force on Returning Global War on Terror Heroes, *Report to the President* (April 2007); Department of Defense Task Force on Mental Health, *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health* (June 2007); President's Commission on Care for America's Returning Wounded Warriors, *Serve, Support, Simplify* (July 2007); Veterans' Disability Benefits Commission, *Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century* (October 2007); and Inspectors General, Department of Defense, *Department of Veterans Affairs, DOD/VA Care Transition Process for Servicemembers Injured in OIF/OEF* (June 2008).

In May 2007, DOD and VA established the SOC as a temporary, 1-year committee with the responsibility for addressing recommendations from these reports. To conduct its work, the SOC established eight work groups called lines of action (LOA). Each LOA is co-chaired by representatives from DOD and VA and has representation from each military Service. LOAs are responsible for specific issues, such as disability evaluation systems and case management. (See table 1 for an overview of the LOAs.) The committee was originally intended to expire May 2008 but it was extended to January 2009. Then, the NDAA 2009 extended the SOC through December 2009.¹²

Table 1: Overview of the Senior Oversight Committee's LOAs

LOAs	Responsibilities
LOA 1: Disability Evaluation System	Addresses efforts to reform the DOD and VA disability evaluation systems.
LOA 2: Traumatic Brain Injury (TBI)/Post Traumatic Stress Disorder (PTSD)	Addresses issues related to TBI/PTSD.
LOA 3: Case Management	Addresses care, management, and transition of recovering servicemembers from recovery to rehabilitation and reintegration.
LOA 4: DOD/VA Data Sharing	Addresses issues regarding the electronic exchange of DOD and VA health records.
LOA 5: Facilities	Address issues relating to military and VA medical facilities.
LOA 6: Clean Sheet Review	Develops recommendations to improve care and benefits without the constraints of existing laws, regulations, organizational roles, personnel constraints or budgets.
LOA 7: Legislation and Public Affairs	Addresses legal and other issues for policy development.
LOA 8: Personnel, Pay, and Financial Support	Addresses compensation and benefit issues.

Source: GAO analysis of SOC documents and interviews with SOC officials.

In addition to addressing the published recommendations, the SOC assumed responsibility for addressing the policy development and reporting requirements contained in the NDAA 2008. Section 1611(a) of the NDAA 2008 directs DOD and VA, to the extent feasible, to develop and implement a comprehensive policy covering four areas: (1) care and management, (2) medical evaluation and disability evaluation, (3) the return of servicemembers to active duty, and (4) the transition of recovering servicemembers from DOD to VA. The specific requirements for each of these four areas are further enumerated in sections 1611 through 1614 of the law and would include the development of multiple policies. Table 2 summarizes the requirements for the jointly developed policies.

¹²Duncan Hunter National Defense Authorization Act for Fiscal Year 2009, Pub. L. No. 110-417, § 726, 122 Stat. 4356, 4509 (2008).

Table 2: Summary of the NDAA 2008 Requirements to Jointly Develop Comprehensive Policy for Improving Care and Management, Medical and Disability Evaluation, Return-to-Duty Decisions, and Transition of Recovering Servicemembers in Sections 1611 through 1614

Key areas of policy development	Summary of requirement
Care and management of recovering servicemembers (section 1611)	Requires DOD and VA to develop policies to address several aspects of access to health care and other assistance, including the training of health care professionals, waiting times, patient tracking, and family support.
Medical evaluation and disability evaluation of recovering servicemembers (section 1612)	Requires DOD to develop policies for improved medical evaluations, DOD and VA to develop policies for improved disability evaluations and report to Congress on the feasibility and advisability of consolidating their disability evaluation systems.
Return of servicemembers who have recovered to active duty (section 1613)	Requires DOD to establish standards for determinations by the military departments on the return of recovering servicemembers to active duty.
Transition of recovering servicemembers from receipt of care and services through DOD to receipt of care and services through VA (section 1614)	Requires DOD and VA to jointly develop and implement procedures and standards for the transition of servicemembers from health care and treatment provided through DOD to care, treatment, and rehabilitation provided through VA.

Source: GAO analysis of sections 1611 through 1614 of the NDAA 2008.

Selected Initiatives of the SOC

Since its inception, the SOC has completed many initiatives, such as establishing the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury and creating a National Resource Directory, which is an online resource for recovering servicemembers, veterans, and their families. In addition, the SOC has undertaken initiatives specifically related to the requirements contained in sections 1611 through 1614 of the NDAA 2008. Specifically, the SOC supported the development of several programs to improve the care and management of benefits to recovering servicemembers, including the disability evaluation system pilot and the Federal Recovery Coordination Program. These programs are currently in pilot or beginning phases:

- **Disability evaluation system pilot:** DOD and VA are piloting a joint disability evaluation system to improve the timeliness and resource use of their separate disability evaluation systems. Key features of the pilot include a single physical examination conducted to VA standards by the medical evaluation board that documents medical conditions that may limit a servicemember's ability to serve in the military, disability ratings prepared by VA for use by both DOD and VA in determining disability benefits, and additional outreach and nonclinical case management provided by VA staff at the DOD pilot locations to explain VA results and processes to servicemembers. DOD and VA anticipate a final report on the pilot in August 2009.
- **Federal Recovery Coordination Program:** In 2007, DOD and VA established the Federal Recovery Coordination Program in response to the report by the President's Commission on Care for America's Returning Wounded Warriors, commonly referred to as the Dole-Shalala Commission. The commission's report highlighted the need for better coordination of care and additional support for families. The Federal Recovery Coordination Program serves the most severely injured or ill servicemembers, or those who are catastrophically injured. These servicemembers are highly unlikely to be able to return to duty and will have to adjust to permanent disabling conditions. The program was created to provide uniform and seamless care, management, and transition of recovering servicemembers and their families by assigning recovering servicemembers to coordinators who manage the development and implementation of a recovery plan. Each servicemember enrolled in the Federal Recovery Coordination Program has a Federal Individual Recovery Plan, which tracks care, management, and transition through recovery, rehabilitation, and reintegration. Although the Federal Recovery Coordination Program is operated as a joint DOD and VA program, VA is responsible for the administrative duties and program personnel are employees of the agency.

Beyond these specific initiatives, the SOC took responsibility for issues related to electronic health records through the work of LOA 4, the SOC's work group focused on DOD and VA data sharing. This LOA also addressed issues more generally focused on joint DOD and VA data needs, including developing components for the disability evaluation system pilot and the individual recovery plans for the Federal Recovery Coordination Program. LOA 4's progress on these issues was monitored and overseen by the SOC. The NDAA 2008 established an interagency program office (IPO) to serve

as a single point of accountability for both departments in the development and implementation of interoperable electronic health records.^{13,14} Subsequently, management oversight of many of LOA 4's responsibilities were transferred to the IPO. Also, the IPO's scope of responsibility was broadened to include personnel and benefits data sharing between DOD and VA.

DOD AND VA HAVE COMPLETED THE MAJORITY OF THE REQUIREMENTS TO JOINTLY DEVELOP POLICIES ON CARE AND MANAGEMENT, MEDICAL AND DISABILITY EVALUATION, RETURN TO ACTIVE DUTY, AND THE TRANSITION FROM DOD TO VA

As of April 2009, DOD and VA have completed 60 of the 76 requirements we identified for jointly developing policies for recovering servicemembers on: (1) care and management, (2) medical and disability evaluation, (3) return to active duty, and (4) servicemember transition from DOD to VA. The two departments have completed all requirements for developing policy for two of the policy areas—medical and disability evaluation and return to active duty. Of the 16 requirements that are in progress, 10 are related to care and management and 6 are related to servicemembers transitioning from DOD to VA. (See table 3.)

Table 3: Summary of Status of DOD and VA Progress to Jointly Develop Policy for Improving Care and Management, Medical and Disability Evaluation, Return-to-Duty Decisions, and Transition of Recovering Servicemembers Required by the NDAA 2008 Sections 1611 through 1614, as of April 2009

Policy area	Number of requirements	Requirements completed	Requirements in progress	Overall status
1. Care and management of recovering servicemembers (section 1611)	38	28	10	☉
2. Medical evaluation and disability evaluation of recovering servicemembers (section 1612)	18	18	0	●
3. Return of servicemembers who have recovered to active duty (section 1613)	1	1	0	●
4. Transition of recovering servicemembers from receipt of care and services through DOD to receipt of care and services through VA (section 1614)	19	13	6	☉
Overall progress	76	60 (79 percent)	16 (21 percent)	☉

Source: GAO analysis of information from the SOC.

Key:

● Complete

☉ In progress

DOD and VA Have Completed More Than Two-Thirds of the Requirements Regarding the Care and Management of Recovering Servicemembers

We found that more than two-thirds of the requirements for DOD's and VA's joint policy development to improve the care and management of recovering servicemembers have been completed while the remaining requirements are in progress. (See table 4.) We identified 38 requirements for this policy area and grouped them into 5 categories. Although 28 of the 38 requirements had been completed, one category—improving access to medical and other health care services—had most of its requirements in progress.

¹³ Pub. L. No. 110–181, § 1635, 122 Stat. 3, 460–63.

¹⁴ Interoperability is the ability of two or more systems or components to exchange information and to use the information that has been exchanged.

Table 4: Status of Requirements to Address the Care and Management of Recovering Servicemembers, as of April 2009

Categories of requirements for care and management	Number of requirements	Requirements completed	Requirements in progress	Overall status
1. Develop policy for training and skills of health care professionals, recovery care coordinators, medical care case managers, and non-medical care managers ^a	2	2	0	●
2. Develop policy for recovery plans for recovering servicemembers and the training, duties, support, and supervision of recovery care coordinators, medical care case managers, and non-medical care managers ^b	20	19	1	●
3. Develop policy for improved access to medical and other health care services ^c	10	1	9	●
4. Develop policy for improved outreach and services for family members of recovering servicemembers ^d	5	5	0	●
5. Apply policy to recovering servicemembers on the temporary disability retired list as determined by DOD ^e	1	1	0	●
Overall progress	38	28 (74 percent)	10 (26 percent)	●

Source: GAO analysis of information from the SOC.

Key:

● Complete

● In progress

^aNDAA 2008, Section 1611(d).^bNDAA 2008, Section 1611(e)(1) – (4).^cNDAA 2008, Section 1611(e)(5) – (11).^dNDAA 2008, Section 1611(f)(g).^eNDAA 2008, Section 1611(h).

Most of the completed requirements were addressed in DOD's January 2009 Directive-Type Memorandum (DTM), which was developed in consultation with VA.¹⁵ This DTM, entitled Recovery Coordination Program: Improvements to the Care, Management, and Transition of Recovering Servicemembers, establishes interim policy for the improvements to the care, management, and transition of recovering servicemembers in response to sections 1611 and 1614 of the NDAA 2008. In consultation with VA, DOD created the Recovery Coordination Program in response to the NDAA 2008 requirements. This program, which was launched in November 2008, extended the same comprehensive coordination and transition support provided under the Federal Recovery Coordination Program to servicemembers who were less severely injured or ill, yet who still were unlikely to return to duty and continue their careers in the military. This program follows the same structured process as the Federal Recovery Coordination Program. However, DOD oversees this program and the coordinators are DOD employees.

DOD's January 2009 DTM includes information on the scope and program elements of the Recovery Coordination Program as well as on the roles and responsibilities of the recovery care coordinators, Federal recovery coordinators, and medical care case managers and non-medical care managers. According to DOD officials, DOD took the lead in developing policy to address the requirements for care and management because it interpreted most of the requirements to refer to active duty servicemembers.

According to DOD and VA officials, the January 2009 DTM serves as the interim policy for care, management, and transition until the completion of DOD's comprehensive policy instruction, which is estimated to be completed by June 2009.¹⁶ This policy instruction will contain more detailed information on the policies outlined in the DTM. A VA official told us that VA also plans to issue related policy guidance as part of a VA handbook in June 2009. The VA official noted that the final form of the policy document would correspond with DOD's instruction.

DOD and VA Have Completed All of the Requirements for Developing Policy on the Medical Evaluation and Disability Evaluation of Recovering Servicemembers

DOD and VA have completed all of the requirements for developing policy to improve the medical and physical disability evaluation of recovering servicemembers.

¹⁵ DOD and VA will also be issuing a joint directive regarding the policies.

¹⁶ DOD issues directive-type memoranda to address time-sensitive actions that affect current policies or that will be developed into new DOD policies. A directive-type memoranda establishes temporary policy and provides DOD the direction to implement the policy when time constraints prevent publishing a new policy or a change to an existing DOD policy.

(See table 5.) We identified 18 requirements for this policy area and grouped them into three categories: (1) policy for improved medical evaluations, (2) policy for improved physical disability evaluations, and (3) reporting on the feasibility and advisability of consolidating DOD and VA disability evaluation systems.

Table 5: Status of Requirements to Address the Medical Evaluation and Disability Evaluation of Recovering Servicemembers, as of April 2009

Categories of requirements for medical and disability evaluations	Number of requirements	Requirements completed	Requirements in progress	Overall status
1. Develop policy for improved medical evaluations ^a	8	8	0	●
2. Develop policy for improved physical disability evaluations ^b	8	8	0	●
3. Report on feasibility and advisability of consolidating DOD and VA disability evaluation systems ^c	2	2	0	●
Overall progress	18	18 (100 percent)	0	●

Source: GAO analysis of information from the SOC.

Key:

● Complete

◐ In Progress

^aNDAA 2008, Section 1612(a).

^bNDAA 2008, Section 1612(b).

^cNDAA 2008, Section 1612(c).

DOD issued a series of memoranda that addressed the first two categories starting in May 2007. These memoranda, some of which were developed in collaboration with VA, contained policies and implementing guidance to improve DOD's existing disability evaluation system. To address the third category in this policy area, DOD and VA have issued a report to Congress that describes the organizing framework for consolidating the two departments' disability evaluation systems and states that the departments are hopeful that consolidation would be feasible and advisable even though the evaluation of this approach through the disability evaluation system pilot is still ongoing. According to an agency official, further assessment of the feasibility and advisability of consolidation will be conducted. DOD and VA anticipate issuing a final report on the pilot in August 2009. However, as we reported in September 2008, it was unclear what specific criteria DOD and VA will use to evaluate the success of the pilot, and when sufficient data will be available to complete such an evaluation.¹⁷

DOD Has Completed Establishing Standards for Determining the Return of Recovering Servicemembers to Active Duty

DOD has completed the requirement for establishing standards for determining the return of recovering servicemembers to active duty. (See table 6.)¹⁸

Table 6: Status of Requirement to Address the Standards for Return-to-Duty Decisions, as of April 2009

Requirement for return-to-duty decisions	Number of requirements	Requirements completed	Requirements in progress	Overall status
1. Establish standards for return-to-duty decisions ^a	1	1	0	●
Overall progress	1	1 (100 percent)	0	●

Source: GAO analysis of information from the SOC.

Key:

● Complete

◐ In Progress

^aNDAA 2008, Section 1613.

¹⁷GAO, Military Disability System: Increased Supports for Servicemembers and Better Pilot Planning Could Improve the Disability Evaluation Process, GAO-08-1137 (Washington, DC: Sept. 24, 2008).

¹⁸The NDAA 2008 directed the Secretary of Defense to respond to this policy requirement. VA does not participate in return-to-duty decisions.

On March 13, 2008, DOD issued a DTM amending its existing policy on retirement or separation due to a physical disability. The revised policy states that the disability evaluation system will be the mechanism for determining both retirement or separation and return to active duty because of a physical disability. An additional revision to the existing DOD policy allows DOD to consider requests for permanent limited active duty or Reserve status for servicemembers who have been determined to be unfit because of a physical disability. Previously, DOD could consider such cases only as exceptions to the general policy.

According to a DOD official, it is too early to tell whether the revisions will have an effect on retirement rates or return-to-duty rates. DOD annually assesses the disability evaluation system and tracks retirement and return to duty rates. However, because of the length of time a servicemember takes to move through the disability evaluation system—sometimes over a year—it will take a while before changes due to the policy revisions register in the annual assessment of the disability evaluation system.

Over Two-Thirds of the Requirements for Improving the Transition of Recovering Servicemembers from DOD to VA Have Been Completed

DOD and VA have completed more than two-thirds of the requirements for developing procedures, processes, or standards for improving the transition of recovering servicemembers. (See table 7.) We identified 19 requirements for this policy area, and we grouped them into 5 categories. We found that 13 of the 19 policy requirements have been completed, including all of the requirements for two of the categories—the development of a process for a joint separation and evaluation physical examination and development of procedures for surveys and other mechanisms to measure patient and family satisfaction with services for recovering servicemembers. The remaining three categories contain requirements that are still in progress.

Table 7: Status of Requirements to Address the Transition of Recovering Servicemembers, as of April 2009

Categories of requirements for improved transition	Number of requirements	Requirements completed	Requirements in progress	Overall status
1. Develop procedures, processes, and standards for care coordination, benefits, and service transition ^a	11	7	4	●
2. Develop procedures and processes for information sharing of military service and health records ^b	5	4	1	●
3. Develop a process for a joint separation and evaluation physical examination ^c	1	1	0	●
4. Develop procedures for surveys and other mechanisms to measure patient and family satisfaction with services for recovering servicemembers ^d	1	1	0	●
5. Develop procedures to ensure the participation of recovering servicemembers of the National Guard or Reserve in the Benefits Delivery at Discharge Program ^e	1	0	1	●
Overall progress	19	13 (68 percent)	6 (32 percent)	●

Source: GAO analysis of information from the SOC.

Key:

● Complete

● In progress

^aNDAA 2008, 1614(a), 1614(b)(1)-(9), (14).

^bNDAA 2008, 1614(b)(10)-(13), (15).

^cNDAA 2008, 1614(b)(16).

^dNDAA 2008, 1614(b)(17).

^eNDAA 2008, 1614(b)(18).

^fThrough the Benefits Delivery at Discharge program, DOD and VA have made efforts to streamline access to veterans' disability benefits by allowing some servicemembers to file a claim and obtain a single comprehensive exam prior to discharge.

Most of the requirements for improving the transition from DOD to VA were addressed in DOD's January 2009 DTM—Recovery Coordination Program: Improvements to the Care, Management, and Transition of Recovering Servicemembers—that establishes interim policy for the care, management, and transition of recovering servicemembers through the Recovery Coordination Program. However, we found that DOD's DTM includes limited detail related to the procedures, processes, and standards for transition of recovering servicemembers. As a result, we could not always directly link the interim policy in the DTM to the specific requirements con-

tained in section 1614 of the NDAA 2008. DOD and VA officials noted that they will be further developing the procedures, processes, and standards for the transition of recovering servicemembers in a subsequent comprehensive policy instruction, which is estimated to be completed by June 2009. A VA official reported that VA plans to separately issue policy guidance addressing the requirements for transitioning servicemembers from DOD to VA in June 2009.

DOD AND VA OFFICIALS EXPERIENCED CHALLENGES DURING JOINT DEVELOPMENT AND INITIAL IMPLEMENTATION OF REQUIRED POLICIES

DOD and VA officials told us that they experienced numerous challenges as they worked to jointly develop policies to improve the care, management, and transition of recovering servicemembers. According to officials, these challenges contributed to the length of time required to issue policy guidance, and in some cases the challenges have not yet been completely resolved. In addition, challenges have arisen during the initial implementation of some of the NDAA 2008 policies. Finally, recent changes to the SOC staff, including DOD's organizational changes for staff supporting the SOC, could pose challenges to the development of policy affecting recovering servicemembers.

Various Challenges Arose during Policy Development

DOD and VA officials encountered numerous challenges during the course of jointly developing policies to improve the care, management, and transition of recovering servicemembers, as required by sections 1611 through 1614 of the NDAA 2008, in addition to responding to other requirements of the law. Many of these challenges have been addressed, but some have yet to be completely resolved. DOD and VA officials cited the following examples of issues for which policy development was particularly challenging.

- Increased support for family caregivers. The NDAA 2008 includes a number of provisions to strengthen support for families of recovering servicemembers, including those who become caregivers. However, DOD and VA officials on a SOC work group stated that before they could develop policy to increase support for such families, they had to obtain concrete evidence of their needs. Officials explained that while they did have anecdotal information about the impact on families who provide care to recovering servicemembers, they lacked the systematic data needed for sound policy decisions—such as frequency of job loss and the economic value of family-provided medical services. A work group official told us that their proposals for increasing support to family caregivers were rejected twice by the SOC, due in part to the lack of systematic data on what would be needed. The work group then contracted with researchers to obtain substantiating evidence, a study that required 18 months to complete. In January 2009, the SOC approved the work group's third proposal and family caregiver legislation is being prepared, with anticipated implementation of new benefits for caregivers in fiscal year 2010.
- Establishing standard definitions for operational terms. One of the important tasks facing the SOC was the need to standardize key terminology relevant to policy issues affecting recovering servicemembers. DOD took the lead in working with its military services and VA officials to identify and define key terms. DOD and VA officials told us that many of the key terms found in existing DOD and VA policy, the reports from the review groups, and the NDAA 2008, as well as those used by the different military services are not uniformly defined. Consequently, standardized definitions are needed to promote agreement on issues such as
 - identifying the recovering servicemembers who are subject to NDAA 2008 requirements,
 - identifying categories of servicemembers who would receive services from the different classes of case managers or be eligible for certain benefits,
 - managing aspects of the disability evaluation process, and
 - establishing criteria to guide research.

In some cases, standardized definitions were critical to policy development. The importance of agreement on key terms is illustrated by an issue encountered by the SOC's work group responsible for family support policy. In this case, before policy could be developed for furnishing additional support to family members that provide medical care to recovering servicemembers, the definition of "family" had to be agreed upon. DOD and VA officials said that they considered two options: to define the term narrowly to include a servicemember's spouse, parents, and children, or to use broader definitions that included distant relatives and unrelated individuals with a connection to the servicemember.

These two definitions would result in significantly different numbers of family members eligible to receive additional support services. DOD and VA officials decided to use a broader definition to determine who would be eligible for support.

Of the 41 key definitions identified for reconciliation, DOD and VA had concurred on 33 as of March 2009 and these 33 standardized definitions are now being used. Disagreement remains over the remaining definitions, including the definition of “mental health.” A DOD official stated that given the uncertainty associated with the organizational and procedural changes recently introduced to the SOC (which are discussed below), obtaining concurrence on the remaining definitions has been given lower priority.

- Improving TBI and PTSD screening and treatment. Requirements related to screening and treatment for TBI and PTSD were embedded in several sections of the NDAA 2008, including section 1611, and were also discussed extensively in a task force report on mental health.¹⁹ DOD and VA officials told us that policy development for these issues was difficult. For example, during development of improved TBI and PTSD treatment policy, policymakers often lacked sufficient scientific information needed to help achieve consensus on policy decisions. Also, members of the SOC work group told us that they disagreed on appropriate models for screening and treatment and struggled to reorient the military services to patient-focused treatment. A senior DOD official stated that the adoption of patient-focused models is particularly difficult for the military services because, historically, the needs of the military have been given precedence over the needs of individual servicemembers. To address these challenges, the SOC oversaw the creation of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury—a partnership between DOD and VA. While policies continue to be developed on these issues, TBI and PTSD policy remains a challenge for DOD and VA. However, DOD officials told us that the centers of excellence have made progress with reducing knowledge gaps in psychological health and TBI treatment, identifying best practices, and establishing clinical standards of care.

- Release of psychological health treatment records to DOD by VA health care providers who treat members of the National Guard and Reserves. Section 1614 of the NDAA 2008 requires the departments to improve medical and support services provided to members of the National Guard and Reserves. In pursuing these objectives, VA faced challenges related to the release of medical information to DOD on reservists and National Guard servicemembers who have received treatment for PTSD or other mental health conditions from VA. DOD requests medical information from VA to help make command decisions about the reactivation of servicemembers, but VA practitioners face an ethical dilemma if the disclosure of medical treatment could compromise servicemembers’ medical conditions, particularly for those at risk of suicide. The challenge of sharing and protecting sensitive medical information on servicemembers who obtain treatment at VA was reviewed by the Blue Ribbon Work Group on Suicide Prevention convened in 2008 at the behest of the Secretary of Veterans Affairs. DOD and VA are continuing the efforts to develop policy to clarify the privacy rights of patients who receive medical services from VA while serving in the military, and a protecting the confidential records of VA patients who may also be treated by the military’s health care system. The need to resolve this challenge assumes even greater importance in light of DOD’s and VA’s increasing capability to exchange medical records electronically, which will expand DOD’s ability to access records of servicemembers who have received medical treatment from VA.

Future Challenges Could Impede the Joint Implementation of Policy Initiatives

In addition to challenges encountered during the joint development of policy for recovering servicemembers, additional challenges have arisen as DOD and VA have begun implementing NDAA 2008 policy initiatives.

- Medical examinations conducted as part of the DOD/VA disability evaluation system pilot. In 2007, DOD and VA jointly began to develop policy to improve the disability evaluation process for recovering servicemembers and began pilot testing these new procedures in the disability system. One significant innovation of the disability evaluation system pilot is the use of a single physical examination for multiple purposes, such as for both disability determinations and disability benefits from both departments. In our review of the disability evaluation system pilot, we reported that DOD and VA had tracked challenges that

¹⁹Department of Defense Task Force on Mental Health (2007).

arose during implementation of the pilot but had not yet resolved all of them.²⁰ For example, one unresolved issue was uncertainty about who will conduct the single physical examination when a VA medical center is not located nearby. Another challenge that could emerge in the future is linked to VA's announcement in November 2008 that it would cease providing physical reexaminations for recovering servicemembers placed on the Temporary Disability Retired List (TDRL).²¹ However, VA made an exception to its decision and will continue to provide reexaminations for TDRL servicemembers participating in the disability evaluation system pilot. In March 2009, VA officials told us that they were developing a policy to clarify this issue.

- Electronic health information sharing between DOD and VA. The two departments have been working for over a decade to share electronic health information and have continued to make progress toward increased information sharing through ongoing initiatives and activities. However, the departments continue to face challenges in managing the activities required to achieve this goal. As we previously reported,²² the departments' plans to further increase their electronic sharing capabilities do not consistently identify results-oriented performance measures, which are essential for assessing progress toward the delivery of that capability.²³ Further challenging the departments is the need to complete all necessary activities to fully set up their IPO, including hiring a permanent Director and Deputy Director. Defining results-oriented performance goals in its plans and ensuring that they are met is an important responsibility of this office. Until these challenges are fully addressed, the departments and their stakeholders may lack the comprehensive understanding that they need to effectively manage their progress toward achieving increased sharing of information between the departments. Moreover, not fully addressing these challenges increases the risk that DOD and VA may not develop and implement comprehensive policies to improve the care, management, and transition of recovering servicemembers and veterans.

Changes to the SOC's Staff and Scope of Policy Development Responsibilities Could Pose Future Challenges

Recent changes to staff and working relationships within the SOC could pose future challenges to DOD's and VA's efforts to develop joint policy. Since December 2008, the SOC has experienced turnover in leadership and changes in policy development responsibilities. The SOC is undergoing leadership changes caused by the turnover in presidential administrations as well as turnover in some of its key staff. For example, the DOD and VA deputy secretaries who previously co-chaired the SOC departed in January 2009. As a short-term measure, the Secretaries of VA and DOD have cochaired a SOC meeting.

DOD also introduced other staffing changes to replace personnel who had been temporarily detailed to the SOC and needed to return to their primary duties. DOD had relied on temporarily-assigned staff to meet SOC staffing needs because the SOC was originally envisioned as a short-term effort. In a December 2008 memo, DOD outlined the realignment of its SOC staff. This included the transition of responsibilities from detailed, temporary SOC staff and executives to permanent staff in existing DOD offices that managed similar issues. For example, the functions of LOA 7 (Legislation and Public Affairs) will now be overseen by the Assistant Secretary of Defense for Legislative Affairs, the Assistant Secretary of Defense for Public Affairs, and the DOD General Counsel. DOD also established two new organizational structures—the Office of Transition Policy and Care Coordination and an Executive Secretariat office. The Office of Transition Policy and Care Coordination oversees transition support for all servicemembers and serves as the permanent entity for issues being addressed by LOA 1 (Disability Evaluation System), LOA 3 (Case Management), and LOA 8 (Personnel, Pay, and Financial Support). The Executive Secretariat office is responsible for performance planning, performance man-

²⁰ See GAO-08-1137.

²¹ Recovering servicemembers may be placed on the TDRL if they are found to be medically unfit for duty and have service-related illnesses or injuries that are not stable enough for assignment of a permanent disability rating. Assignment to the TDRL temporarily retires and provides servicemembers with disability benefits for up to 5 years while they wait for their disabling medical conditions to stabilize. A TDRL retiree must undergo periodic medical reexaminations and evaluations every 18 months. See 10 U.S.C. §§ 1202, 1210.

²² GAO, *Electronic Health Records: DOD's and VA's Sharing of Information Could Benefit from Improved Management*, GAO-09-268 (Washington, DC: Jan. 28, 2009).

²³ These plans are the November 2007 VA/DOD Joint Executive Council Strategic Plan for Fiscal Years 2008–2010 (known as the VA/DOD Joint Strategic Plan) and the September 2008 DOD/VA Information Interoperability Plan (Version 1.0).

agement, and SOC support functions. According to DOD officials, the new offices were created to establish permanent organizations that address a specific set of issues and to enhance accountability for policy development and implementation as these offices report directly to the Office of the Under Secretary of Defense for Personnel and Readiness. Currently, many of the positions in these new offices, including the director positions, are staffed by officials in an acting capacity or are unfilled.

DOD's changes to the SOC are important because of the potential effects these changes could have on the development of policy for recovering servicemembers. However, officials in both DOD and VA have mixed reactions about the consequences of these changes. Some DOD officials consider the organizational changes to the SOC to be positive developments that will enhance the SOC's effectiveness. They point out that the SOC's temporary staffing situation needed to be addressed, and also that the two new offices were created to support the SOC and provide focus on the implementation of key policy initiatives developed by the SOC—primarily the disability evaluation system pilot and the new case management programs. In contrast, others are concerned by DOD's changes, stating that the new organizations disrupt the unity of command that once characterized the SOC's management because personnel within the SOC organization now report to three different officials within DOD and VA. However, it is too soon to determine how well DOD's new structure will work in conjunction with the SOC. DOD and VA officials we spoke with told us that the SOC's work groups continue to carry out their roles and responsibilities.

Finally, according to DOD and VA officials, the roles and scope of responsibilities of both the SOC and the DOD and VA Joint Executive Council appear to be in flux and may evolve further still.²⁴ According to DOD and VA officials, changes to the oversight responsibilities of the SOC and the Joint Executive Council are causing confusion. While the SOC will remain responsible for policy matters directly related to recovering servicemembers, a number of policy issues may now be directed to the Joint Executive Council, including issues that the SOC had previously addressed. For example, management oversight of many of LOA 4's responsibilities (DOD and VA Data Sharing) has transitioned from the SOC to the IPO, which reports primarily to the Joint Executive Council. LOA 4 continues to be responsible for developing a component for the disability evaluation system pilot²⁵ and the individual recovery plans for the Federal Recovery Coordination Program. It is not clear how the IPO will ensure effective coordination with the SOC's LOAs for the development of IT applications for these initiatives. Given that IT support for two key SOC initiatives is identified in the joint DOD/VA Information Interoperability Plan, if the IPO and the SOC do not effectively coordinate with one another, the result may impact negatively on the development of improved policies for recovering servicemembers.

Mr. Chairman, this completes our prepared remarks. We would be happy to respond to any questions you or other members of the subcommittee may have at this time.

CONTACTS AND ACKNOWLEDGMENTS

For further information about this testimony, please contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov, Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov, or Valerie C. Melvin at (202) 512-6304 or melvinv@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. GAO staff who made key contributions to this testimony are listed in appendix II.

²⁴The Joint Executive Council is responsible for addressing strategic issues affecting both departments and developing a joint DOD/VA strategic plan.

²⁵LOA 4 is developing a tracking system for the disability evaluation system pilot that tracks information about servicemembers such as the assignment of a physical evaluation board liaison officer and timeframes for completing the disability evaluation processes.

Appendix I: Summary of Selected Requirements from the National Defense Authorization Act for Fiscal Year 2008

To summarize the status of the Departments' of Defense (DOD) and Veterans Affairs (VA) efforts to jointly develop policies for each of the four policy areas outlined in sections 1611 through 1614 of the NDAA 2008, we identified 76 requirements in these sections and grouped related requirements into 14 logical categories.¹ Tables 8 through 11 enumerate the requirements in each of GAO's categories and provide the status of DOD and VA's efforts to develop policy related to each requirement, as of April 2009.

Table 8: Requirements to Address the Care and Management of Recovering Servicemembers, as Outlined in Section 1611(a)(2)(A), with Specific Requirements Enumerated in Section 1611

GAO category	Number of NDAA 2008 requirements in category	Summary of NDAA 2008 requirements	Status
Develop policy for training and skills of health care professionals, recovery care coordinators, medical care case managers, and non-medical care managers	2 requirements	<p>1611(d): Policy shall provide for uniform standards among the military departments for training and skills of health care professionals, recovery care coordinators, medical care case managers, and non-medical care managers, including tracking notifications made by them. The policy shall:</p> <ol style="list-style-type: none"> 1. Ensure that health care professionals, recovery care coordinators, medical care case managers, and non-medical care managers are able to detect and report early warning signs of post traumatic stress disorder or suicidal or homicidal thoughts or behaviors in recovering servicemembers. 2. Include a mechanism or system to track the number of notifications made by recovery care coordinators, medical care case managers, and non-medical care managers to health care professionals regarding post traumatic stress disorder or suicidal behaviors in recovering servicemembers. 	<ul style="list-style-type: none"> • •
Develop policy for recovery plans for recovering servicemembers and the training, duties, support, and supervision of recovery care coordinators, medical care case managers, and non-medical care managers	20 requirements	<p>1611(e)(1)-(4): To improve the care, management, and transition of recovering servicemembers, the policy shall:</p> <ol style="list-style-type: none"> 1. Provide for uniform standards and procedures among the military services for the development of a comprehensive recovery plan for each recovering servicemember. <p>For recovery care coordinators:</p> <ol style="list-style-type: none"> 2. Provide for a uniform program for the assignment of recovery care coordinators to recovering servicemembers. 3. Include specified duties assigned to recovery care coordinators. 4. Specify the maximum number of cases of recovering servicemembers assigned to a recovery care coordinator. 	<ul style="list-style-type: none"> • • • •

¹We defined an individual requirement as a provision within sections 1611 through 1614 related to the policy required by 1611(a) that directs DOD, VA, or both to take a specific action or to include a specific criterion in their policy. The SOC's legal counsel reviewed these requirements and our groupings, and agreed with our approach.

Appendix I: Summary of Selected
Requirements from the National Defense
Authorization Act for Fiscal Year 2008

GAO category	Number of NDAA 2008 requirements in category	Summary of NDAA 2008 requirements	Status
		5. Specify standard training requirements for recovery care coordinators.	•
		6. Include mechanisms to ensure recovery care coordinators have necessary resources.	•
		7. Specify requirements for supervision of recovery care coordinators.	•
		For medical care case managers:	
		8. Provide for a uniform program for the assignment of medical care case managers.	•
		9. Include specified duties assigned to medical care case managers.	•
		10. Specify the maximum number of cases of recovering servicemembers assigned to a medical care case manager.	•
		11. Specify standard training requirements for medical care case managers.	•
		12. Include mechanisms to ensure that medical care case managers have necessary resources.	•
		13. Specify requirements for supervision of medical care case managers.	•
		For non-medical care managers:	
		14. Provide for a uniform program for the assignment of non-medical care managers to recovering servicemembers.	•
		15. Include specified duties assigned to non-medical care managers.	•
		16. Specify duration of non-medical care managers' duties.	•
		17. Specify the maximum number of cases of recovering servicemembers assigned to a non-medical care manager.	•
		18. Specify standard training requirements for non-medical care managers.	•
		19. Include mechanisms to ensure that non-medical care managers have necessary resources.	•
		20. Specify requirements for supervision of non-medical care managers.	•
Develop policy for improved access to medical and other health care services	10 requirements	<i>1611(e)(5)-(11): Policy shall provide for:</i>	
		1. Appropriate minimum standards for access to non-urgent medical care and other health care services by recovering servicemembers in certain settings.	•
		2. Maximum waiting times for follow-up, specialty, diagnostic, and surgical care.	•
		3. Recovering servicemember's ability to waive access standards.	•
		4. Assignment of recovering servicemembers to locations of care.	•
		5. Reassignment of recovering servicemembers from deficient medical or medical support facilities.	•
		6. Availability of transportation and subsistence when obtaining medical care and services.	•

Appendix I: Summary of Selected
Requirements from the National Defense
Authorization Act for Fiscal Year 2008

GAO category	Number of NDAA 2008 requirements in category	Summary of NDAA 2008 requirements	Status
		7. Assignment of recovering servicemembers to work and duty compatible with their medical conditions.	●
		8. Access to educational and vocational training and rehabilitation.	●
		9. Tracking the location of recovering servicemembers and their compliance with appointments.	●
		10. Referral of recovering servicemembers to VA and other providers.	●
Develop policy for improved outreach and services for family members of recovering servicemembers	5 requirements	1611(f) and (g): Policy shall provide or include:	
		1. Providing support for family members not eligible under section 1672.	●
		2. Providing advice and training to family members for providing care to recovering servicemembers.	●
		3. Measuring family members' satisfaction with quality of health care provided to recovering servicemembers.	●
		4. Procedures for applying for job placement services by family members.	●
		5. Procedures and mechanisms for outreach to recovering servicemembers and family members to inform them of policies on medical care, management and transition of recovering servicemembers, and responsibilities of recovering servicemembers and families.	●
Apply policy to recovering servicemembers on the Temporary Disability Retired List as determined by DOD	1 requirement	1611(h):	
		1. Policy required by this section shall apply to recovering servicemembers placed on the temporary disability retired list as determined by DOD.	●

Source: GAO analysis of section 1611 of the NDAA 2008.

Key:

- Complete
- In progress

Appendix I: Summary of Selected
Requirements from the National Defense
Authorization Act for Fiscal Year 2008

Table 9: Requirements to Address the Medical and Disability Evaluations of Recovering Servicemembers, as Outlined in Section 1611(a)(2)(B), with Specific Requirements Enumerated in Section 1612

GAO category	Number of NDAA 2008 requirements in category	Summary of NDAA 2008 requirements	Status
Develop policy for improved medical evaluations	8 requirements	1612(a):	
		1. The Secretary of Defense shall develop policy to improve processes, procedures, and standards for medical evaluations of recovering servicemembers.	•
		Policy improvements to medical evaluations shall include and address:	
		2. Uniform application of medical evaluation policy throughout the military departments to recovering servicemembers in the regular components of the Armed Forces, National Guard, and Reserves.	•
		3. Standard criteria and definitions for determining maximum medical benefit from treatment for recovering servicemembers.	•
		4. Standard timelines for fitness-for-duty determinations, specialty care consultations, preparation of medical documents, and appeals of medical evaluation determinations.	•
		5. Procedures to ensure assignment of a physician or health care professional to a recovering servicemember, if requested, who is independent of the medical evaluation board and provides appropriate advice.	•
		6. Standards for qualifications and training of medical evaluation board personnel.	•
		7. Standards for the maximum number of recovering servicemember cases pending before a medical evaluation board, and procedures to expand on medical evaluation board if warranted.	•
Develop policy for improved physical disability evaluations	8 requirements	1612(b):	
		1. The DOD and VA Secretaries shall develop policy to improve processes, procedures, and standards for physical disability evaluations of recovering servicemembers by DOD and VA.	•
		Policy to improve physical disability evaluations shall include:	
		2. A clearly-defined DOD and VA process for physical disability determinations for recovering servicemembers.	•
		3. To the extent feasible, procedures to eliminate unacceptable discrepancies and improve consistency among disability ratings assigned by DOD and VA to recovering servicemembers of the Armed Forces, National Guard, and Reserves in the use by each military department of the VA disability rating schedule.	•
		4. Uniform timelines for appeals of disability determinations of recovering servicemembers.	•
		5. Uniform standards for qualifications and training of physical disability evaluation board personnel.	•

Appendix I: Summary of Selected Requirements from the National Defense Authorization Act for Fiscal Year 2008

GAO category	Number of NDAA 2008 requirements in category	Summary of NDAA 2008 requirements	Status
		6. Uniform standards for the maximum number of recovering servicemember cases pending before a physical disability evaluation board, and procedures to expand board.	●
		7. Uniform standards and procedures for providing legal counsel to recovering servicemembers undergoing physical disability evaluation.	●
		8. Uniform standards on the roles and responsibilities of non-medical care managers and judge advocates, and the maximum number of recovering servicemembers assigned to judge advocates at any one time.	●
Report on feasibility and advisability of consolidating DOD and VA disability evaluation processes	2 requirements	1612(c): <i>The DOD and VA Secretaries shall report on:</i>	
		1. The feasibility and advisability of consolidating the DOD and VA disability evaluation systems.	●
		2. Recommendations for options for consolidating the DOD and VA disability evaluation systems, and recommendations for mechanisms to evaluate and assess progress made in consolidating the DOD and VA disability evaluation systems, if consolidation is considered feasible and advisable.	●

Source: GAO analysis of section 1612 of the NDAA 2008.

Key:

- Complete
- In progress

Table 10: Requirement to Address Standards for Return-to-Duty Decisions, as Outlined in Section 1611(a)(2)(C), with Specific Requirements Enumerated in Section 1613

GAO category	Number of NDAA 2008 requirements in category	Summary of NDAA 2008 requirements	Status
Establish standards for return-to-duty decisions	1 requirement	1613:	
		1. The DOD Secretary shall establish standards for determinations by the military departments on the return of recovering servicemembers to active duty.	●

Source: GAO analysis of section 1613 of the NDAA 2008.

Key:

- Complete
- In progress

Appendix I: Summary of Selected
Requirements from the National Defense
Authorization Act for Fiscal Year 2008

Table 11: Requirements to Address the Transition of Recovering Servicemembers, as Outlined in Section 1611(a)(2)(D), with Specific Requirements Enumerated in Section 1614

GAO category	Number of NDAA 2008 requirements in category	Summary of NDAA 2008 requirements	Status
Develop procedures, processes, and standards for care coordination, benefits, and service transition	11 requirements	<i>1614(a), (b)(1)–(9), (14):</i>	
		1. The DOD and VA Secretaries shall jointly develop uniform processes, procedures, and standards for the transition of recovering servicemembers from DOD care to VA care and rehabilitation.	•
		Processes, procedures, and standards shall include:	
		2. Uniform patient-focused procedures.	•
		3. Procedures for identifying and tracking recovering servicemembers during transition, and coordinating and managing their care.	•
		4. Procedures for notifying VA of recovering servicemembers commencing the medical and the physical disability determination processes.	•
		5. Procedures and timelines for enrollment of recovering servicemembers for health care, education, rehabilitation, and other benefits.	•
		6. Procedures for ensuring recovering servicemembers' access to vocational, educational, and rehabilitation benefits during transition.	•
		7. Standards for optimal location of DOD and VA liaison and case management personnel at DOD treatment and other facilities.	•
		8. Standards and procedures for integrated medical care and management of recovering servicemembers during transition.	•
		9. Standards for preparation of detailed, written plans for transitioning recovering servicemembers from DOD treatment to VA treatment and rehabilitation.	•
Develop procedures and processes for information sharing of military service and health records	5 requirements	10. Procedures to ensure that each recovering servicemember being retired or separated receives a written transition plan prior to retirement or separation.	•
		11. Procedures to ensure that the VA Secretary duly considers statements submitted by recovering servicemembers regarding the transition.	•
		<i>1614(b)(10)–(13), (15): The DOD and VA Secretaries shall jointly develop uniform processes, procedures, and standards for:</i>	

Appendix I: Summary of Selected
Requirements from the National Defense
Authorization Act for Fiscal Year 2008

GAO category	Number of NDAA 2008 requirements in category	Summary of NDAA 2008 requirements	Status
		1. Transmittal of necessary records and information of each recovering servicemember being retired or separated from DOD to VA, including military service and medical records, information for entitlement to transitional health care or benefits, and request for assistance in application for VA health benefits, compensation, or vocational rehabilitation.	●
		2. Obtaining authorization by recovering servicemember or legal representative for transmittal of medical records from DOD to VA in accordance with the Health Insurance Portability and Accountability Act of 1996.	●
		3. Transmittal of address and contact information to recovering servicemember's state veterans' agency.	●
		4. Arranging a meeting between the recovering servicemember, his/her family members, and DOD and VA representatives to discuss the transfer of records to VA prior to such transfer with at least 30 days notice.	●
		5. Providing for VA's access to military health records of recovering servicemembers receiving or who anticipate receiving treatment in VA facilities.	●
Develop a process for a joint separation and evaluation physical examination	1 requirement	Subsection 1614(b)(16): 1. The DOD and VA Secretaries shall jointly develop uniform processes, procedures, and standards for a joint physical examination that meets DOD requirements for separation and VA requirements for disability evaluations.	●
Develop procedures for surveys and other mechanisms to measure patient and family satisfaction with services for recovering servicemembers	1 requirement	Subsection 1614(b)(17): 1. The DOD and VA Secretaries shall jointly develop uniform processes, procedures, and standards for surveys and other mechanisms to measure recovering servicemember and family satisfaction with DOD and VA care and services for recovering servicemembers, and to promote oversight of such care and services.	●
Develop procedures to ensure the participation of recovering servicemembers of the National Guard or Reserve in the Benefits Delivery at Discharge Program*	1 requirement	Subsection 1614(b)(18): 1. The DOD and VA Secretaries shall jointly develop uniform processes, procedures, and standards for ensuring that recovering servicemembers of the National Guard or Reserve participate in the Benefits Delivery at Discharge Program.	●

Source: GAO analysis of section 1614 of the NDAA 2008.

Key:

● Complete

● In progress

*Through the Benefits Delivery at Discharge Program, DOD and VA have made efforts to streamline access to veterans' disability benefits by allowing some servicemembers to file a claim and obtain a single comprehensive exam prior to discharge.

Senator BEN NELSON. Ms. Melvin?

Mr. WILLIAMSON. We just have one statement.

Senator BEN NELSON. Thank you very much, Mr. Williamson.

As you look at trying to develop an intercooperative arrangement between two distinct agencies, did you get a sense that maybe there is a tendency for an agency to create a silo for protection or stovepiping, as it's sometimes called? Did you see an indication that that might be broken down to where there truly could be a bridge built between the two agencies to smooth the transition? Obviously, there is a transition in place today, it's just not smooth. Is it possible to smooth it to the level we need and want it to be?

Mr. WILLIAMSON. Mr. Chairman, the SOC was created to deal with a crisis situation, and it was created to overcome the silos that might have existed in both agencies. I think it has enjoyed

some relative success. I think the question now is, with the new organizations on the DOD side that have been created to support the SOC, and with certain other changes, whether that smoothness will continue. Indications that we have so far is that the changes—and granted, the changes have only been in place for 4 months—are being accomplished. Again, I think a large part of the success of the SOC has occurred due to personality-driven kinds of considerations. The people who have been there in the past have gotten along, and they've communicated well up to this point. I think, now, with future changes looming, in terms of top-level people who are going to be leaving and others taking their place, it remains to be seen just how smoothly things will work out.

Senator BEN NELSON. Any comments from either of the other panelists?

Mr. BERTONI. Sure, I could add something from a disability determination perspective.

I have followed this pilot from the initial tabletop exercise through the initial pilot phase with just 3 locations, to now it's up to 14 locations. I can say for both DOD and VA—it's a partnership. They're sharing information, they're trying to flatten the process and the handoff.

I do see an effort to do that, to make it a seamless process, to view this as a continuum of care from the battlefield injury to the stabilization of the person. Then ultimately making a decision on what we will do with this person's future, whether they go back into the Service and have the appropriate supports in play, or to transfer that person into the civilian world and perhaps VA. There's coordination there between the board liaisons and the military Service representatives. There is an effort to do that, certainly. There's always room for improvement, and we can talk about that.

Senator BEN NELSON. Ms. Melvin, I know that a lot of people think that information technology is just something that's essentially mechanical, and if you come up with the same system, everything will transfer. Is that a misnomer here, as well?

Ms. MELVIN. Yes, it is, sir. There's a big issue, relative to interoperability, and that's the critical aspect that has to be into play for VA and DOD to share their electronic health information. Getting to interoperability requires a lot of agreement, relative to standards, and those standards relate to medical terminology, data transfer, just a complex host of issues that have to be considered. It's not a matter of just having systems developed. It is a matter of being able to understand the requirements that each of those departments has. What are the priorities, relative to their needs, and how do you build those systems, and build the interoperable capabilities that will allow the necessary data to be exchanged?

Senator BEN NELSON. Mr. Williamson, is it possible to get the two agencies to determine the same level and interest and need for the same criteria for determination of status of health and whether you're partially incapacitated or grossly incapacitated? Are their interests so different that you can't bring this together with a single set of criteria, or are you hopeful that it's possible to establish a single set of criteria, which would mean coming up with the same language, the same approach, which would make the transfer of records clearly more doable?

Mr. WILLIAMSON. Clearly, Mr. Chairman, the two agencies are distinctly different, even though they share many of the same issues. I think, through the SOC and through the Joint Executive Council (JEC)—which is another DOD/VA coordination body—they have taken steps to come together. As you saw in our written statement, there are issues over definitions.

Senator BEN NELSON. Right.

Mr. WILLIAMSON. Definitions—one that's still being decided is, what is "mental health"? What does it encompass? Certainly, the scope and eligibility and other issues regarding servicemembers depends on having a common understanding of terms.

So, the SOC has worked its way through about three-quarters of the definitions. They're working on the others, but it's not easy.

I think the SOC provides a good vehicle for doing that.

Senator BEN NELSON. I was taken by what Mr. Bertoni said about their willingness to cooperate, and people of goodwill who desire to cooperate typically find a way to make things happen. Those who don't, don't. I might ask, do you think that, in the process, there is a senior partner and a junior partner, or do we have co-equal senior partners between the two agencies?

Mr. WILLIAMSON. I think the two agencies would like to view themselves as equal. There are probably situations where one takes precedence when you're talking about certain issues. Some issues relate more to DOD than they do VA, in terms of Wounded Warrior Units and so on. Naturally, DOD would take the lead in those situations. On other issues, VA might take a lead. But, I think when you're talking about transition issues, they both try to be full partners.

Senator BEN NELSON. I'm encouraged to hear your assurances that it appears that there's a cooperative spirit and a sincere and significant effort to make happen what everybody wants to have happen; a smooth transition for our members and their families.

Mr. WILLIAMSON. One notable thing is that the Secretaries of both DOD and VA have come together and have been real participants in this debate, have participated in SOC meetings, and have participated in JEC meetings. I think that says a lot for what the agencies are trying to do.

Senator BEN NELSON. It certainly sends the right message and lends the credibility that's necessary for this to happen. Thank you.

Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

Mr. Williamson, did you hear the testimony of Lieutenant Kinard, when he was talking about the GAO report that said a program existed, but that you really didn't evaluate the quality of the program. Is that a fair criticism?

Mr. WILLIAMSON. We looked at policy. The first step in this process is, do they have policies in place? I think we said they're doing a pretty good job. I was listening to that testimony, and I thought I would get a question on this.

I think that the proof's in the pudding, in terms of implementation. I think that has to play out for many of these 76 requirements.

There are a couple of things we're going to be embarking on in the near future. We're going to be looking at the FRC/RCC process.

We're going to be undertaking a review of that, which is very much akin to implementation. We're going to be looking at how that's been implemented. Also, we're going to be looking at the DCoE for Psychological Health and TBI, which, again, the SOC has been involved in with respect to the TBI/post-traumatic stress disorder (PTSD) issue. We're going to be looking at those from the standpoint of implementation.

To look at all 76 requirements, in terms of implementation, is a big task. We're going to try to zero in on those that we think are very important and that need to be addressed soon.

Senator GRAHAM. Fair enough. One thing I'd like to just bring to the committee's attention, and to the public and our panel members, is that Colonel Gadson's a good example of how this war is different. He is going to remain on Active Duty it looks like. That just shows you how far we've come, in terms of medical technology and the desire of our soldiers to stay connected to their units and to the military.

There will always be two decisions to be made. The one thing I don't want to do is rush a decision, because I think if it's up to Andrew, in many ways, he'd still be on Active Duty, but he's made the decision to move forward. We have some young men and women serving on Active Duty. I think there's a blind captain who's an instructor at West Point. There are some amputees that are serving. I think that's good.

Just to let my colleagues up here know that there's always going to be some delay in making decisions, because the first decision, as to whether or not you can stay on Active Duty, is an important decision. More times than not, for most of the people hurt, their goal is not to be discharged. I want to make sure that we have a system that looks closely at the ability to continue to serve, and think outside the box, and make places for people like Colonel Gadson and others.

Now, once the decision has been made that you're not going to be able to stay on Active Duty, I do believe that we can do a lot better. The two agencies involved have two different missions. DOD's mission is to take care of soldiers, their families, and fight and win this war. VA is to take care of those who have served. The interim period of time between medical discharge and evaluation and rehabilitation is always going to be complex. This idea of having standard definitions, that mental health services and rehabilitative services, for an Active Duty member, should not be materially different than somebody that goes into the VA. That's what Dr. Noss was telling us, and that's what Colonel Gadson was telling us, that, "When I was an Active Duty person, or I lived in this region, I had certain services available. When I went into this new system—the VA—all of a sudden, my access to outpatient services was limited."

Did you look at that?

Mr. BERTONI. I can talk a bit about that. I've done a lot of work across a lot of different programs, and I can say in many respects, the policies and procedures that pertain to the Guard and Reserve often do put them potentially at a disadvantage. At least there's a belief in many respects. In some cases, we've identified that.

The issue here is when you look at DES, one in four folks coming into that system are either a Guard or Reserve Force member. A larger portion of our standing military is Guard or Reserve.

I've brought this up in other testimonies, and it might be time to start looking at our policies.

Senator GRAHAM. Colonel Rivas was telling us about compensation. He's a reservist. Not 20 years retirement eligible. He has to wait until he's 60.

Mr. BERTONI. There are many issues relating to preexisting conditions and how many guardsmen can get caught in that situation and be aced out of benefits. I think we have policies that were set up when we had this traditional army from many years ago, and we're moving to a new force.

Senator GRAHAM. Do you think both organizations are sensitive to the Guard and Reserve dilemma?

Mr. BERTONI. Yes, I think they are, and in the case of the DES, which we have been able to get behind, versus just saying there's a policy.

Senator GRAHAM. One final area, and I'll yield here. Dr. Noss was talking about when her husband was Active Duty, that when he got out of the Active Duty system, there was a limitation on access to therapy. Did you find that when you were looking at it, that going from one system to the other all of a sudden changed the menu you had to choose from, in terms of therapies?

Mr. BERTONI. No, we didn't look at that specifically. Again, we were following the pilot.

Senator GRAHAM. I think that's what she said. When her husband got discharged, some of the therapies that were available on Active Duty were not available through the VA system. Thank you very much.

Senator BEN NELSON. Thank you, Senator.

Senator BEGICH.

Senator BEGICH. Thank you very much, Mr. Chairman. I want to follow up on the comment from the lieutenant regarding the 76 policies. That's the magic number, and they've done 60, 70 of these, and that you just confirmed that they have the policies in place.

Are you planning, or will you be doing any kind of a measurement of the success of these policies, or is there a baseline to measure against? In other words, I'm going to speak for a moment as a former mayor. When we got audited at times by our internal auditor, we'd write a policy. Satisfied, you check the box and move on. It's when they came back and said, "What did you do?" that was more important. So what's the plan? Or is there a plan? If there's no plan, do we need to help you get a plan on that?

Mr. WILLIAMSON. I mentioned two of the things we're going to be doing.

Senator BEGICH. I heard those, but on these specific—and here's why. I'm walking through the steps, 76 new policies. Of those 76 new policies, what Senator Graham was getting at, and that is now, there should be some measurable method to determine if those policies are working or not. In order to determine that, you have to have a baseline to where they are on every one of those policies and where they hope to go and if they achieve that.

I understand the other 2 you mentioned, but specifically about these 76, who wants to answer? I see Mr. Bertoni.

Mr. BERTONI. I could talk again about this in terms of the disability program. Right now, we have a disability system, the current system that nearly all folks are going through. We have a pilot that we're looking at right now, 14 locations, on its way up to 21 by June. Potential to roll that out worldwide, so that is potentially what will be.

We have been able to look at that pilot. We've been tracking that for over a year, looking at many aspects of what DOD and VA are trying to do there. In many respects, the baseline is, is what is now? What is the current system? What is broken? What are they trying to do? How is the pilot comparing against that existing system?

That at least in this example, that's a baseline in many of the policies that Randy referred to. Modifications of the existing system, and many of the policies that are being folded into the pilot. In some ways, we had looked at, got behind the implementation and effectiveness of some of these policies, at least from the disability standpoint.

Senator BEGICH. What I would like to see is graphically, what happens? In other words, if the person used to take this much time going through the process, how much time does it take him now? He used to receive this much service. Now they're receiving this much service. That's something that you could share at some point, even though it's at a pilot status, of how that is?

Mr. BERTONI. Certainly. The pilot's ongoing, but we issued two testimonies and one report on this. Certainly DOD and VA are tracking timeliness, transparency, customer satisfaction, and measuring it against the existing system. With 14 sites, there is some data coming in, and I could say if you looked at that data, it tends to be trending pretty well.

Our concern is that it is fairly early on. Some of the more high-risk, more difficult sites won't be rolled out until around the time they have to cut off data analysis to begin writing the final report. I don't know if you all will have the data you're looking for, in terms of the effectiveness of this pilot relative to the other system as of August 2009.

Senator BEGICH. Let me follow up on the definition issue. You mentioned—I don't know who mentioned it—about three-quarters of the definitions were agreed to, or there's an understanding. I'm guessing the last quarter is the tougher group. What's the timetable that you think you'll see unification of these definitions?

Mr. WILLIAMSON. In terms of when they'll be—

Senator BEGICH. When they have agreed on it?

Mr. WILLIAMSON. I don't know. I think that's a good question for the next panel. They're the ones doing it.

Senator BEGICH. Next panel, be ready. That's the question. You might just include it in your opening comments so we dispense with it. One other idea I'll just put on the table. Again, I don't know all the technical terms, so I apologize, and you could clarify them for me. As described by the lieutenant, as you're being discharged, there's a process of termination, and then there's a process with the VA. Why not have one board meeting? Why not just

combine them together and have one review at the same time, even though there may be differences in some of the questioning, allow that to occur, and then you're done?

Mr. BERTONI. Again, it is the DES. That's exactly what the pilot is trying to do. Right now, we have a MEB, an informal PEB, then the formal PEB, the DOD rating, the decision on fitness and unfitness.

Senator BEGICH. All at the same time?

Mr. BERTONI. This is the DOD system. Once that occurs, and if the person is found unfit, they'll transition into the civilian world. They'll go through another set of reviews for VA.

What the pilot is trying to do is to move the person through concurrently in these two systems, have the MEB, the PEB, have the VA in there early at the same time doing a comprehensive physical exam, issuing a rating the DOD can use to make the fit/unfit decision and VA will use to ultimately assign a disability rating to the servicemember.

In this situation, the servicemember is going to know pretty much what he or she will receive as soon as he leaves the Service. That's the idea, it is to try to compress this and make separate situations, processes concurrent.

Senator BEGICH. Last question on that. Based on the pilot—and, again, because I'm new here, I don't know what the timetable was. Using just my thinking, it sounds like it's much better than the existing system, no matter how you cut it. There are jurisdictional issues, but if the goal is to deal with the service person as the priority, then the jurisdictional issues should go by the wayside.

Putting that aside for a second, have you or has someone—and maybe it's the next panel—laid out a strategy or timetable, assuming—and that's what I would assume here for a moment—pilots are working, when do we see them all up and operational, so the old system is gone? Is that the next panel?

Mr. BERTONI. We have some information on that. I don't know that we would say it's much better. I think that the jury's out. We have 14 sites. There's limited data that is coming in. They haven't stressed the pilot under a range of scenarios that they could stress it under. There are a number of different bases with different characteristics, and I think they're working toward those farther down the line. I do know they'll be up to 21, I believe, sites by June 2009. They have to issue a final report in August.

I don't know if they're going to say that at that time, that this is ready for further expansion. I think there are another seven sites they might roll out in the fall. But a timeline for worldwide implementation, I haven't seen anything to that effect.

My concern is that they have all the data, and that this be a data-driven decision that they can crank back into any system that is proposed.

Senator BEGICH. Thank you very much. My time is up. Thank you all for your testimony.

Senator BEN NELSON. Thank you, Senator.

Senator Hagan.

Senator HAGAN. Mr. Chairman, I'm going to wait for the next panel, thank you.

Senator BEN NELSON. Thank you. We thank the panel for your appearance here today, for providing us an update and analysis of progress, and we hope that this partnership that you're a part of, as well, will continue into the future. Time is important, but getting it right is also important. So we thank you. Thank you very much.

On our third panel, we welcome Gail H. McGinn, Deputy Under Secretary of Defense for Plans; Ellen P. Embrey, Acting Principal Deputy Assistant Secretary of Defense for Health Affairs; Roger Dimsdale, Executive Director, VA/DOD Collaboration, Office of Policy and Planning for the VA; Major General Keith W. Meurlin, United States Air Force, Acting Director of the Office of Transition Policy and Care Coordination; Rear Admiral Gregory A. Timberlake, United States Navy, Acting Director of the Joint DOD/VA IPO; and Dr. Karen Guice, Executive Director of the Federal Recovery Coordination Program for the VA.

We have many actings here today because of the change in administrations. We're very fortunate to have your testimony, because each of you has played an integral role in developing and implementing these wounded warrior policies. We're obviously counting on you to give us your honest assessment of the work that the departments have completed, as well as areas where problems remain, and work also remains.

We look forward to your statements. Ms. McGinn, if you would like to begin.

STATEMENT OF GAIL H. MCGINN, DEPUTY UNDER SECRETARY OF DEFENSE FOR PLANS, DEPARTMENT OF DEFENSE

Ms. MCGINN. Thank you, Mr. Chairman, Senator Graham, members of the subcommittee. I'm pleased to be with you today to discuss DOD's ongoing effort in collaboration with VA to support America's wounded warriors and their families. I will be addressing the organization DOD has put in place to continue building on the partnership between our two agencies.

DOD has made, in my estimation, an extraordinary organizational commitment to sustaining and enhancing our structures for continued progress on this front. Two years ago, when events brought to light the need for focus on wounded warrior support, the departments moved quickly to put an organizational structure in place to staff the SOC in its decisionmaking and oversight role.

Because we needed to move quickly, the structure was of necessity ad hoc, comprised of borrowed executives, civilian detailees, borrowed military manpower, and contractors. DOD is now replacing this ad hoc staff with permanent employees, including the dedication of three senior executive resources, and over 50 permanent traditional positions.

These are in addition to the resources dedicated to the IPO. Our new structure creates a Director of Transition Policy and Care Coordination and an Office of Strategic Planning and Performance Management, encompassing an executive secretariat for managing SOC and JEC matters. This structure continues the work of the prior organization.

The lines of action continue. Transferred to permanent executives and the functions of a previous senior oversight staff office

transferred to the executive secretariat. This organization has several important features.

First, it solves an organizational issue. There was previously no senior executive charged exclusively with working with VA to achieve a seamless transition for our servicemembers, and now there will be.

It enhances our role with the JEC and the development of the Joint Strategic Plan to drive the improvement and benefits and healthcare for all veterans, in addition to continuing the extraordinary efforts in support of the wounded warrior.

These offices of DOD are co-located with the VA office, a VA/DOD co-location to ensure day-to-day collaboration. In fact, they recently moved to new permanent office space.

I've worked for DOD for decades, and I've never seen faster and more committed progress than that embodied in the accomplishments of the SOC as it addressed the various recommendations of numerous studies and commissions and the challenges given to us by your congressional action.

The DES pilot, the revolution in care coordination and customer care, advances in responding to TBI and PTSD, and progress and sharing of electronic information. This is not all of it, but it is impressive. My colleagues will speak to these and other accomplishments in more detail.

But as you've heard in the first panel, our work on behalf of the wounded warrior is not done. As the GAO representative noted, we are creating new organizations. We are completing our hires and we will ensure that our processes, their collaboration with VA, and for integration into the priority work of DOD are accomplished.

We will establish metrics and evaluation processes to make sure our focus is steady and to make sure that we can see where our policies and practices may break down now that we've started to implement them so that we can find the gaps and fix them.

We will continuously review program implementation to find those policy and program gaps. We will integrate the strategic planning for support of the wounded warrior into the overall plans of the Under Secretary of Defense for Personnel and Readiness so that all of these plans are embedded in the essence of what we do every day in Personnel and Readiness.

We will continue to review the support systems for the wounded and also for their families and loved ones, and continue our focus on customer care. We will continue our emphasis on mental health and the need for psychological fitness.

The commitment of our leadership is unwavering. As noted, Secretary Gates and Secretary Shinseki chaired the SOC during the transition so that we could continue the momentum. Yesterday, Deputy Secretary Lynn and Deputy Secretary Gould from VA co-chaired their first SOC and made a commitment to go forward on behalf of wounded warriors.

Mr. Chairman and members of this subcommittee, we thank you for your continuing support as we strive to work with you to provide the best possible care and opportunities for our heroic wounded warriors and their families. Thank you.

[The prepared statement of Ms. McGinn follows:]

PREPARED STATEMENT BY GAIL H. MCGINN

Mr. Chairman, and members of the subcommittee, it is my pleasure to be here today to discuss with you the Department's ongoing aggressive support of programs for our wounded, ill, and injured servicemembers, veterans and their families. Secretary Gates has affirmed that next to the war itself, support for our wounded, ill, and injured is the Department's highest priority. We have made a lot of progress in the last 2 years, but our work is not done. We very much appreciate your support of our ongoing efforts.

I'm here today to relate the Department's recent establishment of a capability to permanently sustain enhanced joint oversight and management of wounded warrior matters and to continue supporting operations of the Department of Defense (DOD)/Department of Veterans Affairs (VA) Senior Oversight Committee (SOC). Let me first provide some background to talk about how we organized initially, and then I will turn to our new alignment, designed to institutionalize and enrich our oversight and management of wounded warrior matters.

BACKGROUND

Senior Oversight Committee:

In the spring 2007, Secretary Gates requested an oversight committee of senior military and civilian officials be created to make certain that recommendations and mandates from a number of sources, including a Presidential Commission, and legislation were addressed. As a result, the SOC for the Wounded, Ill, and Injured (WII) was established. The SOC is co-chaired by the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs, and brings together on a regular basis the most senior decisionmakers from both Departments to ensure timely decisions and actions. The SOC is the main decision body for oversight, strategy, and integration of proposed measures for DOD and VA efforts to improve seamlessness across an injured servicemember's recovery, rehabilitation, and reintegration continuum.

The two Departments and the SOC have been in the process of implementing more than 600 recommendations from 6 major studies and the National Defense Authorization Acts for Fiscal Year 2008 and Fiscal Year 2009. My colleagues will discuss specific accomplishments, but the initiatives to accomplish these requirements fit within a context of the following fundamental changes:

- Increasing collaboration between DOD and VA on issues to deliver a world class continuum of care for our WII.
- Revamping the approach to care and case management, and fully embracing a customer-centered process that includes involvement of the family and caregivers through the use of the Recovery Care Program and the Federal Recovery Coordination Program.
- Increasing the sharing of medical and beneficiary information between DOD and VA.
- Recognizing psychological fitness is as important as physical fitness.

Overarching Integrated Product Team:

The SOC established an Overarching Integrated Product Team (OIPT) to closely track and coordinate recommendations from studies and reports for successful implementation of appropriate support and care for WII servicemembers. The OIPT reports directly to the SOC and is responsible for coordinating, integrating, and synchronizing actions. The OIPT's mission is to:

- Act as the primary DOD and VA coordinating and functioning agent for all recommendations from reports by commissions, task forces, congressional studies, and NDAA mandates.
- Coordinate analysis and review of recommendations and mandates, and present consolidated decision packages to the SOC.
- Refine strategic program guidance and joint planning objectives in conjunction with the Joint Strategic Plan of the Joint Executive Council (JEC).
- Approve plans, timelines, and proposed actions, and report these to the SOC.
- Maintain close coordination, and integration where possible, with the military Services, Joint Staff, and all pertinent Federal departments/agencies with respect to their efforts to improve care and benefits for WII servicemembers and their families.
- Coordinate public relations and communications efforts internal to DOD and VA and external with outside departments/agencies, Congress, veterans support organizations, the media, and the public.
- Review legislation for actionable and/or reportable items.

- Maintain an electronic database for the complete tracking of actionable items.
- Recommend resourcing solutions.

Lines of Actions:

To organize for responsibility and accountability, the SOC established eight lines of action (LoAs) and assigned the recommendations and mandates consistent with the LoAs missions, which are as follows:

Line of Action 1: Disability Evaluation System. Develop and establish one solution for a DOD and VA Disability Evaluation System using one integrated disability rating system that is seamless, transparent, and administered jointly by both Departments. That system must remain flexible to evolve and update as trends in injuries and supporting medical documentation and treatment necessitates. Streamline the transition process for the servicemember separating from DOD and entering the VA system of benefits.

Line of Action 2: Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). Address improvements in consistency and capability surrounding TBI and psychological health (PH) across the full continuum of care within DOD and VA. The effort has been on the collaborative development and continuous improvement of servicemember/veteran-focused programs dedicated to TBI and PH prevention, protection, identification, diagnosis, treatment, recovery, research, and rehabilitation.

Line of Action 3: Case and Care Management. Coordinate medical and nonmedical care, rehabilitation, benefits, and delivery of services and support that will effectively guide and facilitate servicemembers, veterans, their families, and caregivers throughout the entire continuum of care.

Line of Action 4: DOD/VA Data Sharing. Ensure appropriate demographic, personnel, and medical information on servicemembers, veterans, and their family members is visible, accessible, and understandable through secure and interoperable DOD and VA information management systems.

Line of Action 5: Facilities. Ensure facilities are provided that deliver the care servicemembers and veterans have earned and deserve. In accordance with existing laws and regulations, establish standards for the inspection of quarters used by WII servicemembers; conduct an assessment of the existing DOD medical support infrastructure; and summarize inspection results to Congress. Finally, examine the process of establishing and maintaining medical facility design criteria and make recommendations for improvement.

Line of Action 6: Clean Sheet Review. Provide WII servicemembers and their families the best quality care with a compassionate, fair, timely, and non-adversarial disability adjudication process. An ideal process will be developed for providing care and benefits to WII servicemembers, veterans, and their families. The ideal process will not be constrained by current laws, policies, regulations, organizations, infrastructure, or resources.

Line of Action 7: Comprehensive Legislation and Public Affairs. Coordinate the development of comprehensive legislation that will provide the best possible care and treatment for WII servicemembers and their families. Additionally, keep the public informed of significant accomplishments and events.

Line of Action 8: Personnel, Pay, and Financial Support. Ensure each seriously wounded, ill, or injured servicemember has a level of compensation, benefits, and financial support to maintain their dignity and support their recovery, rehabilitation, and reintegration.

Wounded, Ill, and Injured Senior Oversight Committee (WII SOC Staff Office)

Given the scope and magnitude of the issues addressed and the complexity of integrating recommendations within DOD and VA, the SOC directed the creation of a full time joint-departmental support staff. In the interest of time, the WII SOC Staff Office was staffed with civilian detailees from both DOD and VA, borrowed military manpower, and contractor personnel. It was led by a senior executive detailed from the Department of the Army and a VA detailed senior executive as the Chief of Staff. The WII SOC Staff Office provided assistance, advice, and expertise to facilitate changes to policies, procedures, or legislation so that all recommendations relative to the recovery, rehabilitation, and reintegration of WII servicemembers and their families were effectively and efficiently resolved or addressed. The Staff Office served as the integration focal point to both the SOC and OIPT and tracked the actions overseen by the SOC. The Staff Office was charged with providing senior level

review and advising the SOC on the progress of the WII program. The SOC delegated authority to the Staff Office to task deliverables directly to the LoA representatives to ensure SOC requirements were met. Within the Staff Office, a group of DOD and VA personnel jointly served as points-of-contact within the eight LoAs. In this role, LoA liaisons were responsible for facilitating communication between their LoA and the Staff Office. While the Staff Office served as the administrative body facilitating the efforts of the LOAs and ensuring milestones were met, the substantive work assigned by the SOC was accomplished by the LOAs.

LOA Assignments/Staffing:

When we initially categorized the recommendations to be addressed within the LoAs, we assigned LOA lead responsibilities to senior Department officials who, along with VA co-leads, energized their staffs to meet the requirements of SOC assignments. In some cases, lines of action responsibilities were not clearly in any particular senior official's portfolio, but implementing the recommendations became a Department priority so we made the best functional fit possible. For instance, LoAs 1, 3 and 8 were assigned to senior officials in the Office of the Secretary of Defense, Navy, and Air Force, respectively, none of whom had complete Department responsibilities beforehand for oversight and management of WII SOC recommendations assigned in these LoAs.

As with the WII SOC Staff Office, in many cases, staffing this newly created organization to support the SOC required detailing military and civilian help to LOA leads. Of course, the offices from which these detailees came have had to adjust work and resources accordingly.

The Joint Executive Council

The SOC and its supporting structure were designed to focus on the elimination of deficiencies in the wounded warrior continuum of care. The JEC drives the entire panoply of DOD/VA interagency strategy and policy interactions. It has been co-chaired by the Deputy Secretary of the Department of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness. It oversees the efforts of a Health Executive Council, Benefits Executive Council and Interagency Program Office and all other councils or work groups designated by the co-chairs. The JEC works to remove barriers and challenges which impede DOD and VA collaborative efforts, asserts and supports mutually beneficial opportunities to improve all business practices, ensures high quality cost effective services for both DOD and VA beneficiaries, and facilitates opportunities to improve resource utilization. All this is spear-headed and monitored through a joint strategic planning process that results in recommendations to the Secretaries on the strategic direction for the joint coordination and sharing efforts between and within the two Departments for all overlapping matters. This year, we ensured that the SOC actions and milestones were laid into the JEC Strategic Plan.

ESTABLISHING PERMANENT ORGANIZATIONS

After almost 2 years of SOC operations and achieving what we believe are significant positive outcomes, it became evident that to further enrich oversight and management of this priority mission and to posture the Department for sustaining this level of support to our WII servicemembers and their families, a permanent structure was needed. The Department did not have full-time executive leaders dedicated to DOD/VA collaboration and transition. In order to improve on the integration of DOD and VA into a single team to address wounded warrior needs as well as the integration of these issues into the management framework of the Under Secretary for Personnel and Readiness, the Department has created two new permanent offices in DOD. We believe that establishing these two offices will keep support of the wounded warrior at the forefront in our daily efforts and priorities and give us greater ability to improve the continuum of care with VA for all servicemembers. Additionally, further teaming with our colleagues, we've co-located our two new offices with their VA counterpart liaisons, thereby enhancing our synergistic efforts.

Transition Policy and Care Coordination Office

The Under Secretary of Defense for Personnel and Readiness established late last year the Office of Transition Policy and Care Coordination (TPCC). Maj. Gen. Keith Meurlin, USAF, was appointed Acting Director. The TPCC assumed responsibility for policy and programs related to disability systems, servicemember transition to veteran status, separations from the Armed Forces, case and care coordination, and pay and benefits entitlements for wounded, ill, and injured servicemembers, veterans and their families. These assigned responsibilities include the totality of functions assigned to SOC LoAs 1, 3 and 8, which were originally assigned to Deputy

Under Secretary of Defense for Military Personnel Policy, the Deputy Assistant Secretary of the Navy for Military Personnel Policy, and the Deputy Assistant Secretary of the Air Force for Force Management and Integration, respectively. Additionally, subsets of other responsibilities formerly assigned to Deputy Under Secretaries for Military Personnel Policy and Military Community and Family Policy are now included in the TPCC's portfolio. TPCC assumed responsibility for management and monitoring of performance against DOD/VA Benefits Executive Council (BEC) goals and for coordinating with VA in support of BEC activities. Additionally, TPCC has the authority to enter into agreements, within the scope of assigned responsibilities, with VA and represent OUSD (P&R) as a member on councils and interagency forums established under the authority of the DOD/VA JEC, the BEC and the SOC. The TPCC is up and running and keeping pace with meeting SOC, JEC and BEC requirements. Staffing military and government civilian positions is ongoing, expecting full staff to be in place by the end of this calendar year. Thirty-eight personnel will be reassigned or hired to accomplish these duties.

Office of Strategic Planning and Performance Management/Executive Secretariat to the SOC/JEC

At the same time the TPCC was formed, the Office of Strategic Planning and Performance Management/Executive Secretariat to the SOC/JEC was established. Mr. Clarence Johnson, a Senior Executive Servicemember, was appointed Acting Director. The Executive Secretariat, which aligned some DOD staff—mostly temporary contractor or military—from the WII SOC Staff Office, is up and running as well. We expect to hire a permanent Senior Executive Service Director and the office should be fully staffed by the end of this year. We are adding 14 full time permanent personnel to support this function. This office has many of the responsibilities formerly accomplished by the WII SOC Staff Office, including tracking progress of SOC-directed actions (LOA liaison responsibility as before remains); tracking the status and accomplishment of the more than 600 actions embraced by the two Departments; and in collaboration with VA counterparts, establishing SOC and JEC agendas, scheduling SOC, OIPT and JEC meetings and supporting the oversight functions of the SOC, OIPT and JEC. Additionally, this Office has broadened responsibility to provide the planning and management function for DOD's involvement in the Joint Executive Council, including the Department's role in the development of the JEC Joint Strategic Plan and ensuring the accomplishment of actions identified in that plan. Finally, this Office has responsibility for ensuring the integration of these plans and actions into the structure of the Under Secretary of Defense for Personnel and Readiness strategic planning and performance management processes. The Executive Secretariat reports to the Deputy Under Secretary of Defense for Plans.

OTHER REALIGNMENT NOTES AND CLOSING

I earlier spoke about the alignment of LoAs from the initial SOC support structure to the permanent structure. I indicated that LoAs 1, 3, and 8 were aligned from disparate owners to the TPCC. With the exception of LOA 6 whose work has been completed, the other LOAs remained in place with their missions held constant and their responsibilities captured in SOC LOA assignments.

From the SOC perspective, LOA 4 issues continue to be administered with representatives from DOD and VA. From the JEC standpoint, electronic media was highlighted as outlined in Public Law 110-181—fiscal year 2008, National Defense Authorization Act, Section 1635, with the establishment of the Interagency Program Office (IPO) to focus the integration of electronic health information for the DOD and VA. Rear Admiral Gregory Timberlake has been assigned as the acting Director with a permanent Senior Executive Service solution being pursued and the Deputy position is planned to be filled by a VA Senior Executive Service employee.

As we sustain and enrich our support to the wounded warrior, we aim to continue to build upon the partnership with VA to jointly tackle major issues that emerge in the transition of our servicemembers from active duty to veteran status. Our new structure actually streamlines our processes for DOD/VA collaboration, and progress continues.

Under this new alignment, the SOC has met twice and dealt with very substantive issues. Our two cabinet secretaries chaired a SOC in February. The OIPT continues to meet frequently, bringing key issues to discuss and prepare for the SOC forum and reporting on SOC milestones and achievements. In the future our collaboration should be enhanced through the increased focus on the JEC, made possible by our new organizational structure, and by implementation of a new concept—a Principals' JEC, which would be chaired by our two Secretaries when the business of the JEC requires their personal involvement.

While we are pleased with the quality of effort and progress made, we fully understand that there is much more to be done. We believe we have, thus, postured ourselves to continue providing world-class support to our warriors and veterans while allowing us to focus on our respective core missions. Our dedicated, selfless servicemembers, veterans and their families deserve the very best, and we pledge to give our very best during their recovery, rehabilitation and return to duty or to the society they chose to defend.

Thank you for your generous support of our wounded, ill, and injured servicemembers, veterans, and their families. I look forward to your questions.

Senator BEN NELSON. Thank you.

Ms. Embrey?

STATEMENT OF ELLEN P. EMBREY, ACTING PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Ms. EMBREY. Mr. Chairman, Senator Graham, members of the subcommittee, thank you again for the opportunity to discuss what DOD is doing to improve the quality of care for our wounded warriors with respect to psychological health needs and TBI.

I'm very pleased to be here. It has been my great honor and responsibility over the last 2 years to be the DOD lead in partnership with my counterparts in the VA, Dr. Lou Beck and Dr. Ira Katz, to address the work of line of action 2, which focuses on achieving improvements and help outcomes associated with psychological health, PTSD, and TBI.

Today I also briefly discussed the role of my office in overseeing the health-related aspects of line of action 4, which focused over the last 2 years on DOD/VA sharing of information technology and information.

Regarding line of action 2, the Department is committed to ensuring that all servicemembers, especially those with mental health and TBIs, receive consistently excellent care across the entire care continuum. For both psychological health and TBI, our focus has been on building and sustaining physical and mental resilience and improving the quality and consistency of prevention, protection, diagnosis, treatment, recovery, and transition programs for both DOD and VA.

For TBI, this also includes a significant emphasis on research to clarify and improve clinical diagnostic treatment and rehabilitation technologies and therapies, especially for mild TBI, known as concussion, but also moderate, severe, and penetrating TBIs.

While DOD has been actively expanding and implementing programs on psychological health and TBI, we also have been working to evolve and expand the sharing of medical and beneficiary data as directed by line of action 4. This collaboration has ensured that information is viewable, accessible, and understandable through secure and interoperable information systems and greatly advanced the electronic sharing of benefit, personnel, and health information between the two agencies over the last several years.

Details of these efforts have been included in my submitted testimony for the record. I would also like to add that recently, we have refocused our efforts to commit to build a virtual lifetime electronic record to ensure health and benefit information is available in either system to support the servicemember, veteran, and their families at any time, from the point of accession to burial.

Mr. Chairman, DOD greatly appreciates the committee's strong support and the concern that you have shown for their health and well-being. I stand ready to answer your questions.

[The prepared statement of Ms. Embrey follows:]

PREPARED STATEMENT BY ELLEN P. EMBREY

Chairman Nelson and distinguished members of the committee, thank you for the opportunity to bring you up to date on what the Department of Defense (DOD) is doing to improve the quality of care for our wounded warriors with psychological health needs and traumatic brain injuries (TBIs). I am pleased to be here.

From other witnesses today, you have heard how DOD has organized to address the many recommendations offered to improve care for our wounded warriors. I have had the great honor and responsibility to lead, in partnership with my counterparts in the Department of Veterans Affairs (VA), the work of Line of Action 2, which focused on the recommendations related to psychological health, including post-traumatic stress disorder (PTSD), and TBI. In addition, because I have assumed responsibilities as the acting Principal Deputy Assistant for Health Affairs, I have added oversight of health-related actions of Line of Action 4, DOD/VA Data Sharing Information Technology. Ms. Norma St. Claire, the Director of the Joint Requirements and Integration Office, is the DOD co-lead for DOD's personnel and benefits related LOA4 actions.

The DOD is committed to ensuring that all servicemembers, but especially those with psychological health needs or TBIs, consistently receive excellent care across the entire medical continuum. For TBI, this continuum includes diagnostic categories from mild TBI (also known as concussion) to moderate, severe, and penetrating TBI, including those with the most severe head injuries. For both psychological health issues and TBI, the continuum of care includes prevention, protection, diagnosis, treatment, recovery, and transition from DOD to VA.

In 2007, the Department embarked upon a comprehensive plan to transform our system of care for psychological health and TBI. The plan was based on seven strategic goals:

- Building a strong culture of health leadership and advocacy;
- Improving the quality and consistency of care, across the country and around the world;
- Creating easy and timely access to care, regardless of patient location;
- Strengthening individual and family health, wellness, and resilience;
- Ensuring early identification and intervention for individual conditions and concerns;
- Eliminating gaps in care for patients in transition; and
- Building a network to leverage and/or direct medical and cross-functional research, including new and innovative treatments, technologies, and alternative medicine techniques.

Throughout 2008, we made significant progress toward achieving those goals, and I would like to tell you, briefly, where we are on each of them.

LEADERSHIP AND ADVOCACY

In November 2007, we established the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE). In partnership with VA, academia, and others, the DCoE will lead the effort to develop excellence in prevention, diagnosis, practice standards, training, outreach, and direct care for those with TBI and psychological health conditions, and provide the nexus for research planning and monitoring.

Since its inception, the DCoE has focused its efforts on the development and continuous improvement of a patient-centered network dedicated to all issues related to psychological health and TBI.

IMPROVING THE QUALITY OF CARE

To improve the quality and consistency of mental health care, DOD and VA continue our longstanding effort to develop and update clinical standards and guidelines, which incorporate lessons learned and best practices, and establish evidence-based care as the enterprise standard for acute stress disorder, PTSD, depression, and substance use disorders.

Over the past year, the Clinical Practice Guideline for depression has been updated and entered into the final stages of revision, and revisions to the Guideline on PTSD have been initiated based on emerging best practices. DOD purchased clin-

ical tools and equipment to fully enable our clinicians to provide state-of-the-art care. For example, we have accelerated the purchase of imaging equipment at medical centers with high concentrations of patients with TBI.

The DOD introduced an evaluation tool, the Military Acute Concussion Evaluation tool, to assess the likelihood of mild TBI, and we published clinical guidelines for its management in operational settings. We initiated a certification process for multi-disciplinary teams delivery TBI care in medical treatment facilities, and worked with the United States Central Command to standardize the decision process for determining when to return a servicemember to full duty or to the United States for further treatment.

The Department joined with VA to implement a standardized training curriculum on evidence-based psychotherapy for PTSD. To date, the DCoE's Center for Deployment Psychology alone, or in partnership with other organizations (e.g., Services, MTFs, VA), has trained 1,634 providers from DOD, Federal agencies, and the civilian sector in the use of evidence-based treatments for PTSD (specifically Prolonged Exposure and Cognitive Processing Therapy). Similarly, the DCoE's operational arm for TBI (the Defense and Veterans Brain Injury Center), supported by VA, has trained more than 1,600 medical providers on evidence- and consensus-based treatments.

To recognize the challenging diagnoses, and unique requirements, that can accompany psychological health and TBI wounds, the DCoE worked with the Intrepid Fallen Heroes Foundation to design and begin construction of a new facility, the National Intrepid Center of Excellence.

The new center will provide an interdisciplinary team of clinicians and scientists dedicated to a holistic evaluation and treatment approach for servicemembers with mental health and TBI conditions, and it will provide advanced diagnostics and comprehensive treatment planning for those whose mental health conditions or TBIs are not responding to traditional methods. When the new center is complete, we expect that there will be no finer care available in the country, or perhaps the world, for wounded warriors with these conditions.

In a similar manner, the DCoE, the National Institutes of Health Office of Research on Women's Health, and VA cosponsored a meeting, in October 2008, to identify and explore the existing science on trauma spectrum disorders (such as PTSD and TBI) related to military deployment and, for the first time, addressed the question of how personal differences may impact an individual's response to treatment. We are continuing to work together to further examine outcomes associated with these different treatment modalities.

In January 2009, also for the first time, DOD and VA co-sponsored a conference on suicide prevention entitled, "Building Community Connections: Suicide Prevention for the 21st Century," to foster partnerships between suicide prevention experts in government, medicine, and communities. The conference, which featured a wide range of speakers including psychological health experts, not-for-profit organizations, community leaders, survivors, mental health specialists, and chaplains, focused on four tracks: Clinical Intervention, A Multi-Disciplinary Approach, Practical Applications and Tools, and Research and Academics.

IMPROVING ACCESS TO CARE

To improve access to mental health care, regardless of location, we funded the hiring of additional mental health and other specialty providers by the Services, and implemented a policy that requires first appointment access within 7 days for mental health concerns.

DCoE is leading efforts to standardize DOD telehealth services for psychological health and TBI including the establishment of a Federal Partners Exploratory Committee on telemental health. The Center is working with the MHS' Office of the Chief Medical Officer to define telemental health as a standard of care. Leveraging the capabilities of the Services, TRICARE, and civilian providers, DCoE had recently begun serving as a coordinating and resource center for an emerging telehealth network of systems across DOD. Efforts are focused on establishing a collaborative network to rural and underserved locations by connecting various rural patients with treatment facilities via telehealth technologies, including web-based applications.

STRENGTHENING RESILIENCE AND REDUCING STIGMA

To strengthen resilience to psychological stress and traumatic events, the Department is implementing solid prevention and health protection policies, including removing or mitigating organizational risk factors, bolstering resilience characteristics in our Service personnel, and strengthening family wellness.

To reduce the stigma associated with mental health issues, the Department is mounting a pro-resilience and anti-stigma campaign, and has established a number of effective outreach and educational initiatives. For example, we gained line leadership support for the effort to increase psychological fitness through resilience-building programs. We also eliminated the requirement to divulge combat-related mental health history on security clearance forms.

In November, 2008, with the assistance of the Service Vice Chiefs, DCoE began development of the “Real Warriors, Real Battles, Real Strength” campaign, which stresses the impact of war on servicemembers and emphasizes that seeking help for psychological concerns is a sign of strength. Supporting initiatives already have been implemented across the Services to target their individual cultures. The DOD-wide campaign is scheduled to begin in April 2009.

The DCoE also helped develop educational tools, including a project with the non-profit organization behind “Sesame Street,” to produce more than 700,000 DVDs to help families, and especially children, cope with deployed parents or loved ones. To date, more than 350,000 of these DVDs have been distributed.

One exciting initiative in this area is “SimCoach,” a program currently under development that will allow warriors and families to electronically query top experts in psychological health and TBI, and discuss their injuries with their peers.

Specifically targeted to the Armed Forces younger population, SimCoach will combine the best of simulation, advanced gaming technology, artificial intelligence, and avatar-based computer interaction to encourage warriors and their families to initiate treatment or access educational resources. It will also reduce the stigma associated with seeking psychological health care.

CARING FOR PATIENTS IN TRANSITION

The DOD is working with its Federal and private sector partners to eliminate gaps in care as patients transition through the various health systems, or to different duty locations. For example, we recently established an assisted living pilot program in Johnstown, PA, to improve functionality and independent living after TBI. This program will provide valuable insight for replication in other areas where appropriate. We also provided significant support to DOD/VA efforts to establish the Federal Care Coordination program and stood up a TBI care coordination system to integrate Federal, State, and local resources.

SCREENING AND SURVEILLANCE

To ensure early identification and intervention of mental health and TBI issues, the Department enhanced post-deployment assessments and reassessments. Additionally, in July 2008, the Department began conducting baseline neuro-cognitive assessments on Active and Reserve personnel prior to deployment. To facilitate the continuity of care for veterans and servicemembers, we implemented a common DOD/VA post-deployment TBI assessment protocol, which will allow clinicians, across the enterprise, to collect and access the same information.

We designed and implemented the Mental Health Self Assessment Program, which offers Service personnel and their families the opportunity to identify their own symptoms and access assistance before a problem becomes serious. The self-assessments address PTSD, depression, generalized anxiety disorder, alcohol use, and bipolar disorder, and may be taken anonymously online, over the phone, or at special events held at installations. After completing a self-assessment, individuals receive referral information that includes services provided by TRICARE, Military OneSource, and VA Vet Centers.

MEDICAL AND CROSS-FUNCTIONAL RESEARCH

The Department is building a network in which to leverage and direct medical and cross-functional research that will enhance prevention, detection, diagnosis, and treatment of combat-related psychological health and TBI issues. For example, with the support of the Service Vice Chiefs of Staff and the Surgeons General, DCoE is sponsoring an expedited, intramural (DOD facilities), multi-center randomized clinical trial of hyperbaric oxygen (HBO2) therapy for chronic and mild-to-moderate TBI patients.

The study, which is in the advanced development phase, will answer important questions regarding efficacy in this population, including whether HBO2 therapy should be provided to servicemembers when indicated. Currently, the study is awaiting Investigational New Drug registration by the Food and Drug Administration (FDA). Once FDA approval is obtained, we expect the study to be completed in about 18 months.

The DCoE also participated in blast mitigation studies through and with the United States Army Medical Research and Materiel Command, and is working with external groups, such research universities as the Massachusetts Institute of Technology and Virginia Tech and the National Football League, to explore new ways to mitigate the effect of blast and blunt trauma on our populations.

Together with ongoing research activities supported by the Joint Improvised Explosive Device Defeat Organization, and the Institute of Soldier Nanotechnology, we have learned a great deal about how to keep our servicemembers safe before, during, and after physically traumatic events.

In addition, we initiated numerous research projects to enhance the diagnosis and treatment of TBI and mental health conditions. Indeed, thanks to the tremendous support of Congress, DOD is now one of the world's leading sponsors of such research. The Department has initiated research projects across the continuum of care to further research in the areas of TBI and psychological health, including:

- Basic research directed toward gaining greater understanding of the brain and how it works;
- Applied research to provide more in-depth knowledge of TBI and psychological health prevention, treatment, diagnosis, and recovery techniques;
- Advanced technology development to create new tools, technologies, pharmaceuticals and devices, and treatment protocols to improve prevention, diagnosis, treatment, and recovery;
- Clinical trials to demonstrate the safety, toxicity, and efficacy of candidate pharmaceuticals, prototype medical devices, or protocols benefiting patients diagnosed with TBI or mental health conditions; and
- Complementary and alternative medicine approaches to the treatment of PTSD and TBI, such as yoga or acupuncture.

DOD/VA DATA SHARING

While Line of Action 2 was actively expanding and implementing programs on psychological health and TBI, Line of Action 4 was working closely with our VA partners to evolve and expand the appropriate sharing of medical and beneficiary data between DOD and VA. We have worked closely with multiple program offices in both Departments, as well as the DOD/VA Interagency Program Office, to ensure that information is viewable, accessible, and understandable through secure and interoperable information management systems

We have made great strides forward in the electronic sharing of benefits, personnel, and health information between DOD and VA during the past few years. Intensive planning and collaboration regarding health, personnel, and administrative DOD/VA electronic data exchange continue to enhance the support we provide for our wounded, ill, or injured servicemembers and veterans. Key LOA4 health data sharing accomplishments since February 2007 include the following:

- Initiated electronic transmissions of DOD digital radiographs and scanned medical records from three major DOD Medical Centers to four VA Polytrauma Centers;
- Increased data sharing between DOD and VA from a few DOD sites before July 2007 to all DOD sites today;
- Added procedures, inpatient discharge summaries, Theater clinical data, vital signs, family history, social history, other history, and questionnaires to the data already available between DOD and VA for shared patients;
- Established the DOD-VA Interagency Clinical Informatics Board to give clinicians a direct voice in the prioritization of enhanced health information sharing capabilities that will enhance care delivery for common beneficiaries treated by DOD and VA;
- Increased the availability of inpatient discharge summaries shared with VA from 7 percent of DOD inpatient beds to over 50 percent;
- Enabled the exchange of computable outpatient pharmacy and medication allergy data at all DOD sites; and
- Began implementation activities to support National Guard and Reserve component remote access to AHLTA, DOD's electronic medical record.

We are committed to continue to evolve and expand the appropriate electronic sharing of health, personnel, and benefits information to enhance care delivery and continuity of care for shared patients. In fact, current health information exchange capabilities between the Departments are well ahead of those in the private sector both in scope and scale. The current level of sharing has built a strong foundation for information interoperability needed to achieve our shared vision. Today, this shared information supports the delivery of high-quality healthcare and the administration of benefits to our servicemembers and veterans. With joint leadership,

DOD and VA continue to develop and implement numerous interoperability initiatives. We are delivering information technology solutions that significantly improve the secure sharing of appropriate electronic health, personnel, and benefits information for our shared beneficiaries and support continuity of care for servicemembers transitioning to veteran status.

Another witness, RADM Gregory Timberlake, will provide more information on the Interagency Program Office, which oversees the development and implementation of electronic health record systems or capabilities that allow for full interoperability of personal health care information between DOD and VA.

CONCLUSION

Mr. Chairman, the inspirational author Ralph Marston, tells us that “Excellence is not a skill. It is an attitude.” Throughout DOD, we have adopted an “excellence attitude” about psychological health and TBI and, as a result, we have made remarkable progress in advancing critical solutions to the problems they present for individuals and families.

Mr. Marston also reminds us that, “It takes a long time to bring excellence to maturity.” In that regard, he is also right—which means that, despite the progress, much work remains.

We will continue to work with our private sector care partners to ensure the quality and consistency of care. We will continue to work to meet the needs of our Reserve Forces, especially those in rural or underserved areas. We will continue to do more at the policy level to adapt lessons learned and eliminate gaps in care for those in transition. We will continue to improve our efforts to recruit and retain high quality mental health providers while working with our VA partners to improve utilization strategies. We will continue to pursue every avenue to affect the suicide rates. We will continue to improve our abilities to share and exchange data with VA. We will continue to seek new ways to expand our knowledge and improve our ability to care for our servicemembers, veterans, and their families.

DOD greatly appreciates the committee’s strong support of America’s Armed Forces and the concern you have shown for their health and well being. We have made great progress in meeting the challenges on many fronts and with the committee’s continued help and support, we will do even more.

Thank you for the opportunity to bring you up to date. We look forward to your questions.

STATEMENT OF ROGER DIMSDALE, EXECUTIVE DIRECTOR, DEPARTMENT OF VETERANS AFFAIRS/DEPARTMENT OF DEFENSE COLLABORATION, OFFICE OF POLICY AND PLANNING, DEPARTMENT OF VETERANS AFFAIRS

Mr. DIMSDALE. Good afternoon, Chairman Nelson, Ranking Member Graham, Senator Hagan. I want to thank you for inviting the VA to participate in this hearing. My name is Roger Dimsdale and I’m pinch-hitting for Karen Pane, who’s the acting Assistant Secretary for Policy and Planning. She had a family emergency and was not able to attend.

Before I start with my oral statement, I would like to thank the members of the first panel. I learned a lot by listening to what they had to say. It’s obvious that we have a ways to go. We’re heading in the right direction, but we obviously have placed more emphasis on care and case management. I would also appreciate that my written statement be entered into the record.

Senator BEN NELSON. It will be.

Mr. DIMSDALE. Mr. Chairman, I want to assure you and the committee that Secretary Shinseki is fully committed to supporting America’s wounded warriors and veterans. As a sign of that commitment, Secretary Shinseki has already met with Secretary Gates four times to discuss wounded warrior issues. As Ms. McGinn brought up today, they co-chaired a SOC meeting during the transition.

They have recently agreed to establish a joint Virtual Lifetime Electronic Record (VLER). The latest acronym is VLER, so I'll use the term VLER as we continue through the testimony here. On April 9, the President added support to the VLER. He and the two Secretaries announced the establishment of a joint virtual electronic record. The VLER will be for all current and future servicemembers, veterans, and eligible family members, and will contain all data to uniquely identify them and ensure the delivery of care and benefits for which they're eligible.

The VLER will begin when an individual enters the Service and will continue throughout the period of time he or she is in the Service, into the veteran status, and throughout their life. It will contain health and administrative data, so the idea is this will be one single record, one single virtual electronic record which will track men and women throughout the life span of their service.

VA and DOD, of course, have been working for years on this issue and recently have started to see some progress. Electronic records are a priority of the administration.

Secretary Shinseki intends to do more than talk about it, and he holds our department accountable to accomplish this task. Another important example of an area in which DOD and VA have accomplished joint activity, is the DES pilot. The DES pilot was a demonstration project initially, then in the national capital region, to resolve the confusing aspects of the existing system, and to shorten the overall time required to complete the process.

The pilot is intended for those servicemembers who are being medically separated or retired. The processing time for those currently enrolled in the pilot has been reduced by greater than 50 percent. Our business rule is that servicemembers departing Active Duty will receive their VA disability benefit check the month after they leave Active Duty.

The pilot is currently conducted at 14 sites, with plans to expand and enhance the DES process to another 6 by August 31, 2009. DOD and VA will submit a report to Congress on the lessons learned from the pilot, along with the recommendations as to the way ahead.

As a result of what we've seen so far, VA and DOD would like to extend the policies and lessons learned from the pilot program to additional installations, taking this phased approach to wider implementation of the enhanced process. We'll help ensure success by making sure that we have the right processes in place.

The VA's also very proud of the success of the joint DOD/VA FRCP. Dr. Karen Guice, the Executive Director of the FRCP for VA, is here with me to share with you details about the successes of the FRCP.

We also believe that the successes we have seen in these joint efforts, as well as others I've listed in my written testimony, are the direct result of a structure that allowed us an open dialogue, encouraged collaboration, and focused on results.

We have not changed our level of support for the SOC since it was started in May 2007 and will continue to do so. As you're aware, the NDAA for Fiscal Year 2009, section 726, requires that both departments write Congress on the way ahead for the SOC

and the JEC, and we fully intend to work with DOD to submit a joint report.

While we were pleased with the joint efforts and progress made, there's a good deal more to do. The VA is committed to providing support for our Nation's wounded warriors and veterans. As such, we believe that continued partnership with DOD is critical.

The comment was made earlier in the GAO testimony that working harmoniously is the way ahead, and we are working harmoniously. DOD and VA are hand in hand. Certainly there are issues that take one department's track versus another. But overall, the cooperation has been great and will continue to be so.

Thank you, Mr. Chairman and subcommittee members, for the opportunity. I look forward to answering any questions.

[The joint prepared statement of Mr. Dimsdale and Dr. Guice follows:]

JOINT PREPARED STATEMENT BY ROGER DIMSDALE AND KAREN GUICE, MD, MPP

Good afternoon Chairman Nelson, Ranking Member Graham, and members of the committee. My name is Roger Dimsdale, and I am the Executive Director of the VA/DOD Collaboration Office for the Office of Policy and Planning at the Department of Veterans Affairs (VA). I am pleased to provide the Subcommittee with the accomplishments and challenges related to implementing the various elements of the Wounded Warrior Act. I will also discuss the cooperative efforts between VA and the Department of Defense (DOD) responsible for the progress made to date, as well as our strategy for continued action. First, however, I would like to emphasize the administration's level of support for these activities.

Secretary Gates and Secretary Shinseki have publically articulated their commitment to continued inter-Departmental cooperation. They are particularly supportive of joint activities that resolve issues concerning Wounded Warriors and have met numerous times to affirm their commitment and provide general guidance to staff.

Successful implementation of the various provisions of the Wounded Warrior Act is a direct result of the structured interaction between the two Departments through the Senior Oversight Committee (SOC). The Overarching Integrated Product Team (OIPT), consisting of eight Lines of Action (LOA), supports the SOC. Each LOA is co-led by representatives from VA and DOD. This unique structure coordinates, monitors, and implements the over 600 recommendations from a variety of commissions, task forces, and studies. Currently, the two Departments maintain a collocated staff to support SOC and Joint Executive Committee (JEC) issues. Section 726 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 extended SOC operations until December 31, 2009. VA strictly interprets this mandate and has not changed its approach or organizational support to the LOAs.

I would like to highlight some of the jointly developed and implemented accomplishments resulting from the Wounded Warrior Act. I will focus on the significant improvements to the disability evaluation system (DES), the collaborative efforts addressing psychological health and traumatic brain injury (TBI) through the Defense Centers of Excellence, innovative approaches to care management and coordination, the shared information technology (IT) efforts directed by the Interagency Program Office (IPO), and the various co-developed outreach materials and communication strategies.

DISABILITY EVALUATION SYSTEM

Improvements to the DES and VA compensation and pension program include: (1) the pilot program; (2) revisions to the VA Schedule for Ratings Disabilities (VASRD); and (3) expedited claims processing for Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) veterans by VA.

DOD and VA are currently conducting a pilot program to improve the current disability processes. The project, initially started at the medical treatment facilities in the National Capital Region, is expanding to include other facilities around the Nation. Key features include a single medical examination and disability rating for use by both Departments, as well as a reduction in the time required to transition to veteran status and receive VA benefits and compensation.

Updating the VASRD to reflect the best medical information, and the signature conditions associated with new conflicts, is a priority. New rating criteria for the as-

assessment of residuals of TBI became effective on October 23, 2008. The Veterans Benefits Administration (VBA) is processing claims from very seriously injured and seriously injured OEF/OIF Veterans on a first priority basis. VBA also conducts priority claims processing for initial and reopened claims from all in-theater war veterans received within 6 months after separation from service and appeals from such veterans of the initial claims decisions following such service. Subsequent PTSD claims submitted by returning theater veterans receive priority processing as well.

PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY

The Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury is comprised of an active headquarters element, along with six component centers, including:

- Defense and Veterans Brain Injury Center;
- Center for Deployment Psychology;
- Deployment Health Clinical Center;
- Center for the Study of Traumatic Stress;
- National Intrepid Center of Excellence; and
- National Center for Telehealth and Technology.

Over the past year and a half, the DCoE and its component centers have participated actively in several joint VA/DOD activities, including:

- Developing training programs for DOD and VA personnel for the evaluation and follow-up of patients with TBI—1,500 participants have been trained thus far
- Developing a coding proposal that addresses International Classification of Diseases (ICD-9) coding for TBI, recently reviewed by the National Center for Health Statistics
- Developing Clinical Practice Guidelines for mild TBI, as well as updating the Clinical Practice Guidelines for Substance Abuse and PTSD
- Cosponsoring the Annual Suicide Prevention conference in January 2009, bringing together experts from the Federal and civilian sectors to increase collaboration and communication on the key topic of suicide prevention
- Participating in the Federal Partners Priority Work Group on Reintegration
- Co-sponsoring a scientific conference on gender and racial issues in Psychological Health and TBI on October 1 and 2, 2008 with NIH.

Separately, DOD has provided \$45 million to the DCoE for research to advance the assessment, treatment, and prevention of TBI and psychological health conditions. Five million dollars of these funds is targeted specifically for complementary and alternative medicine approaches to the treatment of psychological health problems and TBI.

CARE COORDINATION AND MANAGEMENT

DOD and VA have made significant improvement to the care and transition of recovering servicemembers. VA and DOD collaborate on issues related to mental and psychological health through a number of interactions, involving the DCoE as well as other mechanisms. Military liaisons at the four major VA Polytrauma Rehabilitation Centers provide a direct connection to the various military services. VA provides liaison officers at selected Military Treatment Facilities (MTF) to assist in delivery of VA care and benefits. Each VA medical center has an OEF/OIF team that facilitates transfers and coordinates VA care at that facility. The military Services have also created service-specific Wounded Warrior Programs to assist recovering servicemembers at each MTF. Finally, the Federal Recovery Coordination Program (FRCP), a joint program of DOD and VA, assists recovering servicemembers, veterans, and their families with access to care, services, and benefits provided through the various programs in DOD, VA, other Federal agencies, states, and private sector.

Recovering servicemembers and veterans are referred to the FRCP from a variety of sources, including from the servicemember's command, members of the multidisciplinary treatment team, case managers, families already in the program, Veterans Service Organizations and nongovernmental organizations. Generally, those individuals whose recovery is likely to require a complex array of specialists, transfers to multiple facilities, and long periods of rehabilitation are referred.

FRCP clients work with their Federal Recovery Coordinator (FRC) to create a goal-based Federal Individualized Recovery Plan (FIRP) with input from their family or caregiver, as well as from members of the client's multidisciplinary health

care team. The FRC implements the plan by working with existing governmental and nongovernmental personnel and resources.

Within the overall framework of care coordination and each client's particular needs and goals, the FRCs work with military liaisons, members of the Services Wounded Warrior Programs, service recovery care coordinators, TRICARE beneficiary counseling and assistance coordinators, VA vocational and rehabilitation counselors, military and VA facility case managers, VA Liaisons, VA specialty case managers, Veterans Health Administration and VBA OEF/OIF case managers, VBA military services coordinators, and others. FRCs do not directly deliver services; they coordinate the delivery of services and serve as a resource for enrolled servicemembers, veterans, and their families.

Currently, 14 FRCs are working at 6 military treatment facilities and 2 VA medical centers. They are supported by a VA Central Office staff that includes an Executive Director, two Deputies (one for Benefits and one for Health), an Executive Assistant, and a Staff Assistant. In addition, the program receives personnel support at VA Central Office from the U.S. Public Health Service and DOD, with each sending two individuals on detail.

INFORMATION TECHNOLOGY COLLABORATION

DOD and VA have taken crucial steps toward creating a Joint Virtual Lifetime Electronic Record (VLER), as announced by President Obama on April 9, 2009. Both Secretaries are dedicated to ensuring strong executive oversight with specific attention to the Interagency Program Office, mandated by the Wounded Warrior Act (title XVI of the National Defense Authorization Act for Fiscal Year 2008), on behalf of VA and DOD, to provide oversight for VA–DOD data sharing initiatives. The emerging vision for the VLER initiative is for all current and future servicemembers, veterans, and eligible Family Members to have a VLER that will encapsulate all data necessary to uniquely identify them and ensure the delivery of care and benefits for which they are eligible. This proactive delivery begins upon oath of military service and continues beyond death to survivor benefits. To the user, the perception will be that one Federal entity delivers all benefits, care, and support.

DOD and VA will develop workgroups to define the common services used by information processes in both Departments as well as the common functional processes within services unique to each Department. Joint DOD–VA efforts have already begun to define the data and business processes for this effort. The result will be an unprecedented unified data sharing between the two Departments.

OUTREACH AND COMMUNICATION EFFORTS

The Wounded Warrior Act called for joint outreach efforts to recovering servicemembers, veterans, and their families. As a result, web-based applications, assistance centers, and direct outreach activities were developed.

The web-based National Resource Directory (the Directory) provides information on services and resources available through Federal, State, and local governmental agencies, veterans' benefit/service/advocacy organizations, professional provider associations, community and faith-based/nonprofit organizations, academic institutions, employers, and philanthropic activities of business and industry. The Directory was developed jointly, and is currently co-managed by DOD, VA, and the Department of Labor.

Other efforts include the Wounded Warrior Resource Center. This consists of a DOD website as well as a call center, and serves as a single point of contact for wounded, ill, and injured servicemembers, their families, caregivers, and those who support them. A MyeBenefits portal, currently under development, will provide individualized information upon login for all servicemembers and veterans.

The National Guard Family Assistance Centers conduct in-person outreach for National Guard members throughout the 50 States, the District of Columbia, and U.S. territories. The Centers augment the support system for geographically dispersed families by providing information, referrals, and assistance to families during a servicemember's deployment. They support any military family member from any military branch or component.

The Yellow Ribbon Reintegration Program provides National Guard and Reserve members and their families with information about services throughout the entire deployment cycle. VA participates in this effort with representation on the Advisory Board and assignment of a VA liaison within the program office.

A handbook was developed by DOD and VA to help injured servicemembers and their families navigate the DOD and VA systems. The handbook is available electronically or in book format.

CHALLENGES

Despite our collective success, we recognize that we have more work to do to implement the Wounded Warrior Act fully. Specifically, we must:

- Maintain a shared structure that continues to provide guidance and oversight for these efforts;
- Continue to work toward one system that supports our wounded warriors;
- Continue to address the unique needs of the National Guard and Reserve components;
- Continue to work toward sharing information between the two Departments; and
- Continue to address the mental health needs, including addressing the stigma that continues to be associated with seeking treatment for mental health disorders.

CONCLUSION

Successful collaboration between the Departments is a direct result of the coordination and oversight of the SOC. Secretary Shinseki and Secretary Gates continue to promote, support and direct these efforts through their actions, including their co-chairing of the SOC and the JEC.

While we are pleased with the joint efforts and progress made, there is a good deal more to do. VA is committed to providing support for our Nation's wounded warriors and veterans. As such, we believe that continued partnership with DOD is critical, and no less than our servicemembers and veterans deserve.

Thank you again for your support to our wounded, ill, and injured servicemembers, veterans, and their families.

We look forward to your questions.

Senator BEN NELSON. Thank you.

General Meurlin.

STATEMENT OF MAJ. GEN. KEITH W. MEURLIN, USAF, DIRECTOR, OFFICE OF TRANSITION POLICY AND CARE COORDINATION, DEPARTMENT OF DEFENSE

General MEURLIN. Chairman Nelson, Senator Graham, thank you for the opportunity to represent DOD and the Office of Transition Policy and Care Coordination this afternoon. I would like to briefly mention a few major areas where my office is currently engaged.

The Physical Disability Board of Review has been established and is up and running. Although we encountered some challenges getting the program started, we're currently making very good progress. We're in the process of reevaluating our approach in two areas and expect significant modifications to be announced in the near future.

The first area pertains to the scope of the review. It is our current intention to review all findings of the PEB, those fitting and unfitting conditions, along with the ratings assigned to those conditions. The second is the service specific DOD guidance that conflicts with the VA's Schedule for Rating Disabilities (VASRD) will be disregarded, and the conditions and rating will be evaluated only with VASRD in effect at the time the initial findings and determinations were made.

We believe both of these changes are consistent with congressional intent, and understand making these changes as soon as possible is a matter of great concern to the committee.

The Recovery Care Coordination program is up and running, with the initial cadre of 31 RCCs deployed to 13 military sites.

My staff is training an additional 100-plus Army AW2 advocates as RCCs using the standard DOD curriculum, which includes standard assessment tools and a comprehensive recovery plan for recovering servicemembers assigned an RCC. The Navy, Marine Corps, and Air Force are assessing how many more RCCs will be needed to ensure our recovering servicemembers are supported.

We have issued interim recovery coordination program policy and the DOD instruction to establish uniform policy—uniform policy for the program implementation and deployment of RCCs and the development of a comprehensive recovery plan.

Ongoing site visits, analysis of the standard assessment tools, and customer satisfaction surveys will allow us to evaluate the program, to assess the population served, and placement of additional RCCs. Recent discussions with the Services indicate that they are on board with these requirements.

The third thing I'd like to mention is the progress we've made in regards to the DES pilot program. There will be a total of 21 sites participating in the program by June and anticipate starting an evaluation in the near future.

The pilot is due to report to the SOC this coming August, and it's imperative to note, however, that the DES pilot is not an end-all solution, but rather a bridge, with the ultimate goal being in integrating DOD and VA systems at logical nodes.

Ultimately, it is time for a national dialogue on how America supports its wounded, ill, and injured. We need to break down more barriers to trust and transparency, and shift away from a focus on paying entitlements to one of recovery, rehabilitation, transition, and making the servicemember a viable member of society.

The Secretary of Defense put in place a voluntary program that provides the ability to expedite a servicemember through the DES. The expedited DES process is a special benefit for those servicemembers who sustain catastrophic injuries or illnesses from combat or combat-related operations, as defined in the policy. The establishment of the policy supports the Department's belief that there must be a special process for those members who sustain catastrophic disabilities while participating in combat or combat-related operations, in contrast with those disabled otherwise.

We are excited about this program because it allows the early identification of a full range of benefits, compensation, and specialty care offered by VA.

Finally, in the area of personnel pay and financial support, I'd like to bring your attention to the concept of caregiver compensation. The Center for Naval Analyses (CNA) is completing a study of wounded warrior caregivers, identifying that mothers and spouses spend on average up to a year, and in severe cases, much longer, providing physical and emotional support to their recovering servicemembers.

The final report from CNA will be published shortly. Based on CNA's preliminary findings which were released in December, the Department proposed legislation for fiscal year 2010 to provide catastrophically wounded servicemembers with a special monthly compensation for their caregivers. The amount of the compensation would be based on the monthly income of a home health care aide

and would continue until the catastrophically wounded servicemember transitions to VA.

My bottom line is that America's families turned over their loved ones to us. We're returning some of them wounded, ill, and injured. The servicemembers and their families earned and deserve to have the best that we have to offer. We pledge to continue the work with your staff, VA, the Department of Labor, and others, to make that happen.

Thank you for this opportunity. I look forward to your questions. [The prepared statement of General Meurlin follows:]

PREPARED STATEMENT BY MAJ. GEN. KEITH MEURLIN, USAF

Mr. Chairman, subcommittee members, I am pleased to be here today to discuss with you the Department's continued support of our wounded, ill, and injured servicemembers, veterans, and their families, and in particular, the continued work of the Office of Transition Policy and Care Coordination.

BACKGROUND

On 14 November 2008, the Under Secretary of Defense for Personnel and Readiness established the Office of Transition Policy and Care Coordination (TPCC). It's mission is to ensure equitable, consistent, high-quality care coordination and transition support for members of the Armed Forces, including wounded warriors and their families through appropriate interagency collaboration, responsive policy and effective program oversight. The TPCC assumed responsibility for policy and programs related to the Disability Evaluation System, servicemembers' separation from the Armed Forces and transition to veteran status, wounded warrior case and care coordination, and related pay and benefits. These assigned responsibilities include the totality of the Department of Defense (DOD) functions formerly assigned to the DOD and Department of Veterans Affairs (VA) Wounded, Ill, and Injured Senior Oversight Committee (SOC) Lines of Actions (LOAs) 1, 3, and 8. The TPCC also assumed responsibility for management and monitoring of performance against DOD/VA Benefits Executive Council (BEC) goals and for coordinating with VA in support of BEC activities. The TPCC has the authority to enter into agreements with VA and represent the Under Secretary of Defense for Personnel and Readiness as a member on councils and interagency forums established under the authority of the DOD/VA Joint Executive Council (JEC), the BEC and the SOC. A TPCC Strategic Plan has been created incorporating objectives from the Under Secretary of Defense for Personnel and Readiness and the JEC.

DISABILITY EVALUATION SYSTEM (LOA-1)

The mission of LOA-1, Disability Evaluation System (DES), is to develop and establish one solution for a DOD and VA DES that is seamless, transparent, and administered jointly by both Departments and uses one integrated disability rating system, streamlining the process for the servicemember transitioning from DOD to VA. That system must remain flexible to evolve as trends in injuries and supporting medical documentation and treatment necessitates. LOA-1 has continued to make significant steps forward in regards to the DES Pilot to include the pilot's expansion, the Expedited DES, and the Physical Disability Board of Review.

Disability Evaluation System Overview

Now, as in the past, the DOD remains committed to providing a comprehensive, fair, and timely medical and administrative processing system to evaluate our injured or ill servicemembers' fitness for continued service using the DES. One way we have honored these men and women, was to develop and establish a DES pilot that provides one solution for a DOD and VA DES using one integrated disability rating system. This system has several key features: simplicity; non-adversarial processes; single-source medical exam and disability ratings (eliminating duplication); seamless transition to veteran status; and strong case management advocacy. The system must remain flexible to evolve as trends in injuries and supporting medical documentation and treatment necessitates. LOA-1 has continued to make significant progress in regards to the DES Pilot to include the Pilot's expansion, the Expedited DES, and the Physical Disability Board of Review. However, it is time for a national dialogue on how America supports it wounded, ill, and injured. We need to break down more barriers to trust and transparency, and shift away from

a focus on pay and entitlements to one of recovery, rehabilitation, transition, and making the veteran a viable member of society.

Disability Evaluation System Pilot

During the reporting week ending April 19, 2009, 80 servicemembers entered the DES Pilot from 14 Military Treatment Facilities (MTFs) for a cumulative enrollment of 1,929 servicemembers since 26 November 2007. Of those, 344 servicemembers have completed the DES pilot by returning to duty, separating from service, or retiring. Seventy servicemembers were removed from the DES pilot for other reasons such as transferring to a location outside the DES pilot or case termination for pending administrative discharge processing. Currently, 1,515 servicemembers remain enrolled in the DES pilot.

Active component servicemembers who completed the DES pilot averaged 271 days from Pilot entry to VA benefits decision, excluding pre-separation leave. Including pre-separation leave, Active component servicemembers completed the DES pilot in an average of 286 days. This represents a process which is 47 percent faster than the current DES and VA Claim process, and 3 percent faster than the 295 days originally projected for the pilot. Reserve component and National Guard servicemembers, who completed the DES pilot, averaged 249 days from pilot entry to issuance of the VA benefits letter, which is 18 percent faster than the projected 305 day timeline.

DES Pilot Expansion

Based on guidance from the SOC, the DES pilot will expand to a total of 21 sites by June, 2009. In addition to the locations in the National Capital Region, which include Fort Belvoir and Fort Meade, the following expansion sites are now operating or are prepared to commence DES pilot operations:

- Naval Medical Center San Diego, CA and Fort Stewart, GA, as of November 2008
- Camp Pendleton, CA, as of January 2009
- Naval Medical Clinic Bremerton, WA, Vance Air Force Base, OK, and Fort Polk, LA, as of February 2009
- Nellis Air Force Base, NV, MacDill Air Force Base, FL, and Marine Corps Base Camp Lejeune, NC, as of March 2009
- Fort Drum, NY, and Fort Richardson, Fort Wainwright, and Elmendorf Air Force Base, AK, will commence operations on April 30, 2009

Studies, Reports, and Policy Updates

Data gathering and analysis are ongoing to support an August 2009, expansion decision by the SOC and delivery of a final report to Congress as required by National Defense Authorization Act (NDAA) 2008, section 1644(g)(3). Reports DOD previously delivered to Congress include:

- Feasibility of combining DOD and VA DESs (NDAA 2008, Sec. 1612)
- Report on rating reductions after Physical Evaluation Board appeals (NDAA 2008, Sec. 1615(e))
- Initial and Interim Status reports on the DES Pilot (NDAA 2008, Sec. 1644)
- Initial Report on Army Medical Action Plan action to improve Army DES (NDAA 2008 Sec. 1645)
- Report on the continuing utility of the Temporary Disability Retirement List (NDAA 2008, Sec. 1647)

Additionally, DOD continues to learn lessons from the pilot and capitalize on a continuous improvement process. Since August 2007, the Department, with VA coordination, has published seven policy updates. We will continue to refine the DES until national reform is complete.

Expedited DES

The Secretary of Defense established a voluntary program that will expedite a servicemember through the DES. The Expedited DES process is a special benefit to those servicemembers who sustain catastrophic injuries or illnesses from combat or combat-related operations as defined in the policy. The establishment of the policy supports the Department's belief that there must be a special process for those members who sustain catastrophic disabilities while participating in combat or combat-related operations, in contrast with those disabled otherwise.

To qualify, a servicemember's condition must be designated as "catastrophic" and the injuries or illnesses must have been incurred in the line of duty and received as a result of the causes prescribed under the statutory definition of "Combat-Related" as used in the combat-related special compensation program. Under the Expe-

dated DES, servicemembers receive a presumed 100 percent disability retirement from DOD. The Expedited DES process will allow the early identification of the full range of benefits, compensation and specialty care offered by the Department of Veterans Affairs.

Physical Disability Board of Review (PDBR)

On January 12, 2009, the PDBR began accepting applications. As of April 22, 2009, the board received 306 applications. The board forwarded 148 cases to the military Services and 117 to the VA for records retrieval. The board has 19 complete records assembled and ready for adjudication and has closed 22 cases for administrative reasons. The board members have been assigned, trained on the PDBR process, and have received rating training from VA as well as cross training in other Service disability processes. The Central Adjudication Unit is 100 percent operational and has been permanently occupied since February 16, 2009. The Air Force, acting as the lead component of the PDBR, has negotiated privileges for direct computer access to VA claims records.

CARE COORDINATION (LOA-3)

The mission of LOA-3, Care Coordination, is to simplify the care coordination process by providing uniform standards for wounded, ill, and injured servicemembers and their families throughout their continuum of care from recovery, rehabilitation, and return to duty or reintegration into the community.

Comprehensive Policy for Care, Management, and Transition of Recovering Servicemembers

A DOD Directive Type Memorandum, "Recovery Coordination Program: Improvements to Care, Management, and Transition of Recovering Servicemembers", was published and implemented by the Services' Wounded Warrior Programs in January 2009. A working group chaired by the Care Coordination Office in the Office of Transition Policy and Care Coordination is now writing the DOD Instruction to fully address the NDAA fiscal year 2008 requirements to establish Recovery Care Coordinators (RCCs) and a Comprehensive Recovery Plan for all recovering servicemembers. Members of the working group include representatives from the Service Wounded Warrior Programs, Surgeons General, Assistant Secretaries for Manpower and Reserve Affairs, Health Affairs and, Family Support Programs, the Joint Chiefs of Staff, Joint Task Force National Capital Region Medical, OSD Reserve Affairs, Services' Reserve Components, and the Department of Veterans Affairs.

Recovery Care Coordinators

Currently there are 31 RCCs deployed across the United States at 13 MTFs and installations. The RCCs have been trained using uniform, standard DOD curriculum, as required by Congress. This week my staff is training an additional 100 plus Army AW2 advocates as RCCs using this uniform standard curriculum.

Recovery Coordination Program Evaluation

Preparation for the initial baseline evaluation of the DOD Recovery Coordination Program (RCP) is well underway. Metrics are currently being established to evaluate the program, and assess the current RCC workload. Customer satisfaction surveys will be administered to recovering servicemembers and families enrolled in the RCP and assigned an RCC.

Data Collection/Sharing

The TPCC has instituted a "strategic pause" to review all existing DOD/VA data sharing systems that pertain to the DOD and VA RCPs. The study is reviewing and cross-walking the Services' Wounded Warrior Program existing data collection systems.

We are also conducting a review in mid-May of the standardized screening and assessment tools used to refer recovering servicemembers into the RCP. The results of this review and the IT Study will be incorporated into a solution for a data collection/sharing system for the RCPs. The data collected will be used to help determine workload and future deployment of RCCs. I've asked for the study results and recommendations by the end of May.

National Resource Directory

The DOD, VA, and DoL Web site continues to provide services and resources for wounded, ill, and injured servicemembers, veterans, their families, and those who support them. It is an online tool for accessing more than 10,000 services and resources at the national and State level to support recovery, rehabilitation, and reintegration into the community. A recent informal survey reported 90 percent of our

RCCs are using the National Resource Directory to assist them in the establishment of Comprehensive Recovery Plans and providing services and resources for our recovering servicemembers and their families.

PERSONNEL, PAY, AND FINANCIAL SUPPORT (LOA-8)

The mission of LOA-8, Personnel, Pay, and Financial Support, is to ensure each wounded, ill, or injured servicemember has a level of compensation, benefits, and financial support to maintain their dignity and support their recovery, rehabilitation, and reintegration.

LOA-8's accomplishments have continued with the launch of the Navy Wounded Warrior Database on 29 January 2009 and the release of the updated Electronic Compensation and Benefits Handbook in February 2009. LOA-8 has orchestrated advancements in data sharing between the VA and the Defense Finance and Accounting Service for Active Duty servicemembers who are being treated as inpatients at VA Medical Centers. Additionally, LOA-8 has continued to work closely in cooperation with VA in development of the eBenefits portal with the next two updated releases expected to be delivered in June and September 2009 respectively.

CLOSING

We are extremely proud of the progress made to date. Our obligation to our servicemembers, veterans, and their families is a lifetime pledge which requires our unwavering commitment to complete the work which has been started. There remains more work to do. Our valiant heroes and their families deserve our support and dedication to ensure their successful transition through recovery, rehabilitation, and return to duty or reintegration into their communities.

Thank you for your generous support of our wounded, ill, and injured servicemembers, veterans, and their families. I look forward to your questions.

Senator BEN NELSON. Thank you, General.
Admiral Timberlake?

STATEMENT OF RADM GREGORY A. TIMBERLAKE, USN, DIRECTOR, INTERAGENCY PROGRAM OFFICE, DEPARTMENT OF DEFENSE/DEPARTMENT OF VETERANS AFFAIRS

Admiral TIMBERLAKE. Senator Nelson, Senator Graham, thank you for this opportunity to address you on the status of our, by which I mean DOD and VA, efforts to achieve full interoperability between the electronic health care records and those departments by September of this year.

Let me begin with some background on the DOD/VA IPO, which had its genesis in the language of section 1635 of the NDAA for Fiscal Year 2008, which mandated that DOD and VA achieve fully interoperable electronic health record capabilities by September 2009, and established the IPO to oversee and help coordinate this effort.

On April 17, 2008, VA and DOD officially formed the IPO. Within VA, the IPO was set up to report to the Deputy Secretary. Within DOD, IPO coordinates most of its activities through the Defense Human Resource Activity and the Office of the Under Secretary of Defense for Personnel and Readiness.

The IPO receives strategic guidance from the Secretaries of DOD and VA, as well as from the JEC, which you've heard described earlier, the Health Executive Council for health-related data sharing, and the Benefits Executive Council for personnel and benefits data sharing.

In the early months, IPO was focused on the basics of acquiring office space, equipment, determining appropriate staffing levels, and beginning the process in advertising for personnel. Today, just under half of the permanent staff have been hired, standard oper-

ating procedures are in place, and a formal charter has been signed by the Deputy Secretary of VA and the Under Secretary of Defense for Personnel and Readiness, which specifies the scope of IPO's oversight responsibilities, and further clarifies the relationship of the IPO to the two departments.

The current mission of our office is to provide management oversight of joint activities to accelerate that exchange of the electronic health care information between the departments. In this capacity, IPO is responsible for working with the departments on issues like supporting the definition of DOD and VA data-sharing requirements and showing that DOD and VA schedules are coordinated for the technical execution of the initiatives; assisting in the coordination of funding considerations; and assisting on obtaining input and concurrence of the multiple stakeholders.

Originally, we expected to focus our efforts on the electronic health care record systems and other health care data-sharing initiatives between DOD and VA. However, the scope was later expanded at the suggestion of the Wounded, Ill, and Injured SOC to include personnel and benefits electronic data-sharing as well.

Responsibility for development of their requirements and the execution of information technology solutions still remained with the respective DOD and VA organizations. Technical execution also remains in the appropriate departmental offices, using the departments' established statutory and regulatory processes for acquisition, funding, management control, information sharing, and other execution actions, which are significantly different in each department.

For the immediate term, IPO has centered its energies on ensuring that by September of this year, the systems are in place to allow for full interoperability of the electronic personal health information required for clinical care between DOD and VA. A key to that has been the adoption of a shared DOD and VA understanding of the meaning of the phrase "full interoperability."

In our view, that phrase is best defined by the people who are using the systems daily to deliver care. With this in mind, we turn to the DOD/VA Interagency Clinical Informatics Board (ICIB), which is composed of clinicians from both DOD and VA. It is headed by the Deputy Assistant Secretary of Defense for Clinical and Program Policy and the Chief Patient Care Services Officer of the Veterans Health Administration (VHA).

This group was given the responsibility for identifying and prioritizing the types and format of electronic medical information which clinicians need in order to provide the highest levels of care. In July 2008, the ICIB delivered these recommendations to the IPO and the Health Executive Committee (HEC), Information Management/Information Technology, Working Group.

The recommendations were subsequently approved at the HEC, and then passed down to our DOD and VA information technology teams as they developed the tools and applications to put these requirements into operation. By leveraging many prior accomplishments to the departments toward the development of interoperable bidirectional electronic health records, the IPO and the departments were able to formulate a plan to achieve full interoperability for clinical care by the September 2009 target date.

As a part of this plan, VA's and DOD's ability to utilize well known interoperability systems, like the Federal Health Information Exchange and the Bidirectional Health Information Exchange, has been greatly expanded. At the same time, new systems have been added to the Clinical Data Repository/Health Data Repository to allow even more medical data to be transferred between the two departments.

New pilot programs such as the SHIE imaging project, were developed. This pilot is now deployed and operational at a number of major military and VA medical centers across the country.

Today, I'm pleased to report that I feel we are on target to achieve full interoperability of electronic health records for the delivery of clinical care by September 2009 as defined by the ICIB.

But information technology is not static. As new systems for capturing, storing, archiving, and retrieving patient data are developed, we need to make sure that those systems are built in such a way that they allow the data to be fully shared between DOD, VA, and authorized private sector providers, such as our TRICARE network and the VA contract care network.

As I've previously mentioned, on April 9, 2009, the President announced a new vision for how this would be achieved, centering on the development of a "virtual lifetime electronic record," which Mr. Dimsdale has already alluded to. This virtual lifetime record will leverage investments already made in the existing DOD and VA electronic record systems, as well as industry best practices, to provide a system that will network with new and legacy applications.

Right now, we believe it will be based on a "common services" approach that focuses on the development of standardized software applications to provide links between health care and benefits databases across the two departments. Timing is still in the early stages, but the way ahead looks promising, and I personally would look forward to briefing you on the progress, our progress on meeting the President's new initiative in the future.

Thank you, sir. That concludes my statement, and I look forward to your questions.

[The prepared statement of Admiral Timberlake follows:]

PREPARED STATEMENT BY RADM GREGORY TIMBERLAKE, USN

INTRODUCTION

Chairman Nelson and distinguished members of the committee, thank you for the opportunity to discuss the role of the DOD/VA Interagency Program Office (IPO) in the ongoing effort to achieve fully-interoperable electronic healthcare information sharing between the Department of Defense (DOD) and the Department of Veterans Affairs (VA). We continue to make great strides in sharing electronic healthcare information, and have plans to do even more in the near future.

The sharing of electronic health data has made significant progress in recent years. I will provide a brief historical overview of these efforts, outline some of the initiatives that form the foundation for future sharing efforts, and discuss how the IPO has successfully managed to grow into the institution that is envisioned by Section 1635 of the National Defense Authorization Act (NDAA) for Fiscal Year 2008.

HISTORICAL OVERVIEW

The Departments began laying the foundation for interoperability in 2001, when they first shared healthcare information electronically. Since that time, both Departments have continued to enhance and expand the types of information that is shared, as well as the ways in which it is shared. The following examples illustrate some of the successes of the Departments' ongoing datasharing initiatives:

- The Federal Health Information Exchange (FHIE) data repository allows electronic health information to be shared on over 4.7 million separated servicemembers.
- The FHIE allows DOD and VA providers to access and view 71 million laboratory results, 11.6 million radiology reports, 73.1 million pharmacy records, 75.8 million standard ambulatory records, and 3.1 million consultation reports, and 2.5 million deployment health assessments for shared patients.
- The Bidirectional Health Information Exchange (BHIE) enables bidirectional real-time sharing of readable electronic health information between DOD and VA for shared patients.
- Since July 2007, BHIE data from all DOD and VA medical facilities are available to VA and DOD providers.
- As of February 2009, health data is available through BHIE for more than 3.3 million shared patients, including over 117,900 Theater patients.
- BHIE also provides bidirectional access to inpatient discharge summaries from DOD's inpatient documentation system. This capability is operational at some of DOD's largest inpatient facilities representing approximately 51 percent of total DOD inpatient beds. DOD will increase the number of sites with electronic inpatient documentation system in fiscal year 2009.
- In addition to sharing viewable test data, DOD and VA have expanded the BHIE capability to support the sharing of digital radiology images. The Departments have expanded the BHIE Image Pilot to support the bidirectional exchange of digital images at key locations. The technical accomplishments and lessons learned from the bidirectional image pilot will be used in broader image sharing planning activities.
- Since 2006, DOD and VA have been sharing computable outpatient pharmacy and allergy data through the interface between the Clinical Data Repository of AHLTA, DOD's electronic health record (EHR), and VA's Health Data Repository (HDR) of HealtheVet Vista. This initiative is called "CHDR".
- CHDR integrates outpatient pharmacy and medication allergy data for shared patients that is viewable by providers in both Departments. Exchanging standardized pharmacy and allergy data on patients supports better patient care and safety through the ability to conduct drug-drug and drug-allergy interaction checks using data from both systems.
- In December 2007, all DOD facilities received the capability to initiate the exchange of this data on shared patients.

By working together with the senior leadership of DOD and VA, policies have been established that enable each Department to address its unique requirements while also addressing shared requirements. This coordination has been furthered through the formation of oversight and governing bodies that ensure that information sharing efforts move in the right direction and at a pace that meets or exceeds the expectations of our stakeholders. Today, these efforts support the delivery of high-quality healthcare, continuity of care, and the administration of benefits to our servicemembers and veterans.

THE FOUNDATION FOR INTEROPERABILITY

National Defense Authorization Act for Fiscal Year 2008:

Section 1635 of the NDAA of 2008 requires DOD and VA to jointly develop and implement electronic health record capabilities that allow for full interoperability of personal health care information by September 2009. Section 1635 also requires the development of a DOD/VA IPO to act as a single point of accountability in the rapid development and implementation of EHR systems or capabilities that allow for full interoperability of personal healthcare information between DOD and VA.

On April 17, 2008, a major milestone was met when the two Departments formed the IPO. In December, the DOD Delegation of Authority Memorandum, Establishment of the DOD/VA IPO within the Under Secretary of Defense for Personnel and Readiness was signed.

The IPO's original focus was on EHR systems and other healthcare datasharing initiatives between DOD and VA. The scope of the IPO was later expanded by the Senior Oversight Committee (SOC) at the recommendation of the Overarching Integrated Product Team (OIPT) to include personnel and benefits electronic data sharing. The responsibility for developing requirements and technical execution of information technology solutions remains with the respective DOD and VA organizations. Technical execution will also remain in the appropriate DOD and VA offices, using the Departments' respective established statutory and regulatory processes for

acquisition, funding, management control, information assurance, and other execution actions.

The IPO oversees actions to accelerate the exchange of healthcare information between the Departments. In this capacity, the IPO is responsible for working with the Departments on joint functional activities such as supporting the definition of DOD/VA datasharing requirements, ensuring DOD/VA schedules are coordinated for the technical execution of the DOD/VA datasharing initiatives, assisting in the coordination of funding considerations, and assisting in obtaining the input and concurrence of stakeholders. Additionally, the IPO monitors and provides input on personnel and benefits electronic datasharing initiatives between DOD and VA.

In order to provide initial staff for the IPO, an Acting Director from the DOD and an Acting Deputy Director from the VA were detailed to the IPO, along with four military personnel. In August 2009, all four of these military personnel will be retired from active duty service. In January 2009, I was appointed as the acting Director of the IPO. Mr. Cliff Freeman is the acting Deputy Director. The IPO's initial full staffing structure consists of two Senior Executive Service positions, 14 DOD and VA civilian Government Service positions, and a small contingent of contracted employees (up to 16). Of the government positions, three VA employees and one DOD employee are now hired and working. Candidates for four of the remaining positions have been selected, and another six are in the final approval process. Additional staffing includes the possible hiring of another six contract support personnel. Ten contracted support staff are currently working on a full-time basis at the IPO.

Governance:

The mission of the IPO will evolve over time. Currently, it provides a forum for high level coordination and guidance to ensure that full interoperability is achieved. In this role, the IPO will work in parallel with, and build upon the successes already achieved by the DOD/VA Joint Executive Council (JEC) and the SOC.

The IPO receives guidance from the Secretaries of DOD and VA, and the JEC. The IPO works collaboratively with the Health Executive Council (HEC) for health related data sharing and the Benefits Executive Council (BEC) for personnel and benefits data sharing. The JEC provides leadership oversight of the HEC and BEC, as well as other councils or work groups designated by the co-chairs. If the IPO has issues that cannot be resolved at the HEC and BEC levels, we raise those issues up to the JEC.

DOD/VA Interagency Clinical Informatics Board:

Early on, the IPO and the Departments agreed to turn to the Interagency Clinical Informatics Board (ICIB) to assist in the prioritization of DOD/VA health data interoperability initiatives. The ICIB is a professional organization comprised of clinicians from both DOD and VA. The Deputy Assistant Secretary of Defense for Clinical and Program Policy and the Chief Patient Care Services Officer, Veterans Health Administration, serve as its lead functional proponents. Through the ICIB, we enable the clinical community to define the items that must be shared by September 2009 in order to achieve full interoperability. Once the ICIB's needs for electronic data sharing are identified and prioritized, their recommendations are forwarded to the HEC for review and approval. Upon approval by the HEC, the list of priorities is handed off to requirements and definition teams, and then to our information technology teams to develop applications and tools to put them into operation.

STRATEGY AND PLANNING TO MEET THE INTEROPERABILITY DEADLINE

The Departments and the IPO developed two key documents to serve as guides in our ongoing interoperability efforts. The DOD/VA Information Interoperability Plan (IIP) was signed September 15, 2008, delivered to Congress, and released to the Government Accountability Office. The IIP is updated and resubmitted annually. This document describes the current state of electronic data sharing between the Departments and provides the broad, strategic organizational framework for current and future work. It also establishes the scope and general milestones necessary to measure progress toward intermediate and long term goals. As capabilities become approved and funded, definitive milestones are incorporated into the DOD/VA Joint Strategic Plan (JSP). The JSP represents an effort to provide a more detailed roadmap for the Departments' interoperability goals.

Together, the IIP and the JSP provide the Departments with a clear strategy to achieve our short-term, medium-term, and long-term electronic data sharing goals. By leveraging the prior accomplishments of the Departments toward the development of interoperable bidirectional electronic health records, efforts to achieve full

interoperability of patient healthcare data are currently on track to meet the September 2009 deadline, in accordance with the plans laid out in the IIP and the JSP.

CONCLUSION

Beyond the 2009 Target for Interoperability:

Efforts are underway to deliver full interoperability for the provision of clinical care by September 2009, and expanded interoperability capabilities beyond September 2009. However, both Departments and the IPO recognize that "interoperability" does not have a discrete end point, as technologies and standards continue to evolve. The Departments and the IPO will continue to take a leading role in the continued development of electronic health records data sharing.

Looking ahead, the Departments believe that they are close to settling on a dramatic new approach to information sharing that takes advantage of cutting-edge developments in the information technology industry to create a single virtual lifetime electronic record that captures a servicemember's relevant health and benefits information from the time of accession to the time of burial. Through the Departments' joint adoption of a strictly-defined set of uniform software standards, an architectural framework can be created that is capable of integrating the best software health information technology systems from both the private sector and the government. This method of information-sharing has the potential to revolutionize the way that health and benefits data is shared between the Departments. Preliminary strategic-level planning for this effort is now underway.

Thank you for the opportunity to address the committee, and to provide you with an update on the important work that we are doing to improve and advance electronic health information sharing between the DOD and the VA. I look forward to keeping you apprised of our progress as we move forward in support of our wounded, ill, and injured servicemembers, veterans, and their families.

Senator BEN NELSON. Thank you, Admiral.
Dr. Guice?

STATEMENT OF KAREN S. GUICE, M.D., M.P.P., EXECUTIVE DIRECTOR FOR THE FEDERAL RECOVERY COORDINATION PROGRAM, DEPARTMENT OF VETERANS AFFAIRS

Dr. GUICE. Good afternoon, Chairman Nelson, Ranking Member Graham, and Senator Hagen, Lieutenant Colonel Gadson, Lieutenant Colonel Rivas, Mrs. Rivas, Dr. Noss, and Lieutenant Kinard. Your strength and perseverance is a standard for all of us. Sixteen months ago, the FRCP was created to address services and benefits coordination problems across two large, complex systems of care and benefits.

The FRCP is a joint program of DOD and VA, with VA serving as its administrative home. It is designed to provide oversight and coordination for very seriously or catastrophically wounded, ill, or injured servicemembers, veterans, and their families.

To do so, the FRC develops a customized individual recovery plan that is used to monitor and track the services, benefits, and resources needed to accomplish the identified goals. The goals were those of the servicemember or veteran with input from their family or a caregiver and members of the multidisciplinary team. The number and types of goals are related to the medical problems, the stage of recovery, and the holistic needs of the family and client.

Developing goals is a methodical process that begins with evaluation. FRCs review the relevant records and discusses specific challenges with the various healthcare providers and case managers. This appropriation allows for a structured dialogue with the client in developing the plan. The FRC and the relevant case manager determine responsibility and the timeline for implementing the steps necessary to reach a goal.

The FRC then monitors progress with the case manager and the client, providing support and additional resources to both until the goal is reached. FRCs frequently organize meetings with providers, case managers, and clients to make sure objectives and expectations are clear. The plan and the goals change as the client progresses through the stages of recovery, rehabilitation, and reintegration.

The FRC provides a single consistent point of coordination throughout this progression. Accountability for the plan rests with the FRC. Today, 14 FRCs are located at 6 military treatment facilities and 2 VA medical centers. All have a clinical background, with most being nurses or social workers. One is a vision rehabilitation specialist. All have prior experience in either the military or VA health care system.

Collectively, they have over 200 years of professional experience, all at a Master's level, and many have advanced practice degrees. All have specialized knowledge in either one or more clinical areas. They frequently consult each other, bringing their collective knowledge and experience to bear for their clients.

Currently, 257 clients are enrolled in the program. Seventy-five percent of these are still Active Duty. Generally, these clients are very seriously or catastrophically ill or injured and require a complex array of specialists, multiple interfacility transfers, and lengthy rehabilitation. Individuals are either referred to the program or identified by FRCs from daily census lists and during attendance at specialty team care meetings or downrange video conferences.

On the back of our newly designed brochures is the new toll-free number to make it easier to refer potential clients or get additional information about the program. A description of the program is on the National Resource Directory's Web site and the VA's Operation Iraqi Freedom Web site. The program has a strategy to reach out to those who went through the system prior to its inception and who might still benefit from a recovery plan and care coordination.

Care coordination improves service integration among different delivery systems and eases transition from one system of care to another. It's not a bandaid or an indication of failing systems. Instead, it is another step in the evolution toward a fully integrated system where care and benefits are organized around the multiple needs of individuals across the care continuum.

FRCs, in keeping with this concept, coordinate the delivery of services and resources for servicemembers, veterans, and their families, in accordance with the goals identified in the plan. They work with military Services, RCCs, Tricare, VHA, VBA, other governmental resources, including State and local agencies, as well as the private sector. For those servicemembers and veterans not enrolled in the program, there are a variety of other programs, services, and resources designed to meet their needs through the DOD and VA. I appreciate your input and collaboration as the program matures, and I particularly appreciate your support, and I look forward to your questions. Thank you.

Senator BEN NELSON. Thank you. You were all here and heard my comments about stove piping and the silo effect of agencies. Based on everything that you've heard thus far, and the GAO re-

port, are you all of the opinion that we're breaking that down here so we can have a fully integrated system to smooth the transition and have it for every step along the way, including every aspect of the servicemember's life, as well as his or her family's? Is that fair to say, that what might have been there in the past is not there today?

Ms. MCGINN. Senator Nelson, I think we have to be constantly vigilant because of the nature of our organizations. I do think in the last 2 years, watching the collaboration between DOD and VA, at the highest level, not at the patient care level, has been extraordinary. I think one of the indications of that is the development of this FRC, where the SOC decided they wanted there to be one definitive person, and that person was decided that they would be administratively done by VA.

I think that at our organizational high level, the co-location of the offices, the people that we have put in place in an acting capacity, continue to build relationships with VA.

Going forward, we not only have SOC issues that we work together on, but also JEC issues, which are the issues that cover all of the matters between DOD and VA, and we need to strengthen those relationships.

DOD is leaning forward to do that and avoid having the kinds of silos that we've had in the past. As I said in opening remarks, we never really had a senior executive dedicated to breaking down those silos before, in terms of collaboration with VA, and now we will, so I'm hopeful for that.

Senator BEN NELSON. Is that generally shared?

Mr. DIMSDALE. Sir, I would like to add my comments. It's not Kumbaya. Nothing is Kumbaya, but we talk daily. We sit side-by-side and work daily, and so the silos are breaking down. But there's a lot of work to continue. I want to assure you that it's an ongoing effort, and we're doing everything we can to move the ball in the right direction.

Senator BEN NELSON. Are you in a position where if you run into a question of legal authorities, that you could bring back to us any kind of statutory change that might be necessary to further break it down or to establish this integrated system?

Mr. DIMSDALE. I believe so, sir.

General MEURLIN. Mr. Chairman.

Senator BEN NELSON. Sure.

General MEURLIN. To bring it down to a lower level from what Ms. McGinn was talking about, we recently invited the Medical Director of the Richmond VA Polytrauma Unit to go over on a C-17—go over to Landstuhl and look at the operation there, collaborate with DOD physicians at the receiving point from the area of responsibility, and then come back in that operation.

We're going to expand that program to the other VA Polytrauma Units. We're planning those forces together, which I think will help out in easing the transition and acceptance of patients as they come back.

Yesterday, at the SOC that was mentioned earlier, in reviewing a way ahead for the DES system, the larger look at it, we saw both Deputy Secretaries, really, I think, in quite agreement and accord, which set a tone for the rest of the organization. So as Roger said,

we have offices together in the palatial Hoffman Building down in the south end of Alexandria, and we're working together with staffs and mixing them. I think we're making great progress on that.

Senator BEN NELSON. You mentioned on the FRCP that a decision was made as to which agency would probably be in the best position to administer this. Are you finding other areas where assigning one of the agencies the responsibility makes more sense than both agencies trying to coordinate work together on it?

General MEURLIN. Sir, since Dr. Guice and I have been working quite closely and commiserating on the two different bits of law, one that established the FRCs and then, later on, the NDAA that established the RCCs. Really pretty parallel programs. The question is, as we work through this, since they are so parallel, why not bring them both together? I think probably the initial intent was to have one program cover all niches, the FRCs for the ones that are most seriously injured and destined to depart from DOD and move into VA. But also, the Category 2, the middle level, that really are up in the air whether they will progress medically to return to duty or then depart.

So I think there's a lot of questions there. I know that was the number-one priority or the number-one recommendation of the Dole-Shalala Commission. It's one that I think we're making progress in that area. I think it's going to be absolutely significant to the success of the recovery and reintegration of our soldiers, sailors, airmen, and marines.

Senator BEN NELSON. Dr. Guice?

Dr. GUICE. I'd just agree with him.

[After reviewing the transcript, Dr. Guice submitted the following change to the previous statement: "I'd strongly agree with him."]

Senator BEN NELSON. Other comments that you might want to make about this progress?

Ms. EMBREY. Sir, I think VA has long been a source of expertise for PTSD and for severe TBIs within the Federal Government, and DOD has learned from its expertise and has been partnering with them on a variety of protocols, standards, and guidelines.

We believe so strongly that when we set up our Center of Excellence within DOD, we made our deputy for that center a VA employee who retains employment with VA to ensure close integration of the programs of care for both DOD and VA through that Center of Excellence.

Senator BEN NELSON. If the military can have joint commands, it would seem to me the agencies can find a way to do some of this jointly as well, recognizing how important it is, but also how common it can be to have both agencies have similar responsibilities because of the needs.

Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. This has been a very informative hearing, I think. To all who attended, thank you. This has helped the committee a lot, and we appreciate your time.

I think we are making progress. I guess from the 30,000-foot view of things, number one, you get injured, I want to make sure that you get a fair evaluation as to whether or not you're fit for duty. Right, General?

First thing is, can this servicemember return back to service. Do you agree with that?

General MEURLIN. Absolutely.

Senator GRAHAM. Is that kind of a hope and dream of most people that are injured?

General MEURLIN. It is. Most people that are injured, the different hospitals and patients that I've visited with, that's their ultimate objective. Now, the question which was brought up in the first panel is, is that in their best interest?

Even in the expedited process, we made sure that it was a provision that even though if they're catastrophically wounded, we expedite the DES process, and they leave the Service, that if they do retain a level that they can come back, that we allow for that provision to petition to come back.

Senator GRAHAM. The only reason I mentioned that is the Colonel Gadsons of the world. There's no other time in American history that someone like him would be able to serve. The one thing you want to do is to have a system that can capture people like him, but realize that a lot of these young men and women are going to have to move on to civilian life. All of them can't be integrated back into the military, so let's not lose sight of that.

One of the goals is to make sure that the Colonel Gadsons of the world and others have a chance to continue to serve. Now, once the decision has been made that you're not going to be able to stay on Active Duty, I think that the goal here, between the two of you all, is the same. That when you leave DOD, I just want to make sure that when you go into the VA system, that whatever rehabilitative services you had as an Active Duty member, are not lost because your status changes. But here's the real problem. Most of these services are provided by centers that are exceptional. The Guard member, the reservist, or the person being discharged, may go back to a home area that's not nearly as robust as what WRAMC provides.

That is what Dr. Noss is trying to tell us. Let's make sure that you could go back to Allendale, SC, for the medical requirement, where you're a guardsman or reservist. There's just going to be limitations as to the rehabilitation services available to you.

What I want to do is make sure that whatever is available, that it's available as soon as possible, and we think outside the box. The goal is to reintegrate people in society. To come up with—I don't know if it's a voucher plan. I don't know exactly what it is. But the moment you hit medical retirement, the moment you go back into the civilian community, whether you're a guardsman or a reservist or medical retired Active Duty person, you go to a rural area, we want to do as much as far as you can, understanding there are limitations. Apparently, there are some areas of improvement there.

The second problem is, General, you were talking about a report coming out in December, how the Nation can help care providers, family members who are going to provide care, income-wise. That is coming out in December. Is that right?

General MEURLIN. The preliminary study that CNA did, their preliminary results came out in December. The final results are going to be coming up very shortly.

Senator GRAHAM. The final results will suggest to Congress that we create a revenue stream greater than we have today?

General MEURLIN. Yes, sir. There's proposed legislation coming forward for compensation for caregivers, that will provide for a benefit for caregivers equal and approximate to what a caregiver commercially would be earning.

Senator GRAHAM. That would last for how long?

General MEURLIN. As long as the individual requires.

Senator GRAHAM. Okay. I think that is a great idea, because we focus on the wounded warrior and their family member. They have to drop most of their hopes and dreams. That's just the way it is, and we want to help them where we can. Finally, Mr. Dimsdale, you were talking about standardized definitions. Mental health services available through DOD should be the same as VA when somebody falls into these programs. Whatever rehabilitative services, whatever definitions we have, are we moving down the road to getting standardization?

Mr. DIMSDALE. Yes, sir, but it is not easy.

Senator GRAHAM. I know it would be hard.

Mr. DIMSDALE. This is anecdotal, but there were like 45 definitions we were working on, and I think we got agreement on about 35 out of the 45. There are policies, as far as benefits are concerned, based on the definitions. We are continuing to wicker this thing down, but we have a ways to go.

Senator GRAHAM. The category of somebody who's medically retired, not fit for duty, that, to me, is your first evaluation to make. Once that happens, what's the problem after that?

Mr. DIMSDALE. I'll give you an example. When you asked the question, I was writing notes and trying to get some answers. I'll give you an example. The definition of catastrophically injured entitles people to different things.

Senator GRAHAM. Based on what organization you're in, DOD versus VA?

Mr. DIMSDALE. As far as the determination of what is catastrophic? So Joe or Jane get injured, and we call them catastrophically injured. One agency may say one thing. Another may say another. What the individual gets is based on the definitional acceptance.

Senator GRAHAM. Are there differences within the Services, or just VA/DOD?

Mr. DIMSDALE. I cannot answer that, sir. I would have to get back—

Senator GRAHAM. But you know that is a definitional problem?

Mr. DIMSDALE. Yes, sir.

Ms. EMBREY. My sense is that it's a difference between DOD and VA. The authorization and the way the defense health program is set out and the benefits and whether we have prime and basic and different other kinds.

Senator GRAHAM. You're on to the problem. Just keep us informed. The more standardization, the easier it is for the case manager and the troops and their family to get through this thing. I know it's hard, but like Senator Nelson said, we're joining everybody else. It was hard. I never thought I'd be in an office.

I went and did some Reserve duty in Iraq, and there was a coast-guardsmen there. That's the first guy I met, and he said, "What the hell are you doing here?" We had people from everywhere, every branch of the Service guarding the Service. You couldn't tell the difference. This stuff does work.

Thank you, Mr. Chairman.

Mr. DIMSDALE. Sir, let me do my homework, and we will get back to you for the record.

Senator GRAHAM. Sure, that's good.

[The information referred to follows:]

On 10 December 2008, the Overarching Integrated Product Team approved 33 wounded, ill, and injured related standard terms and definitions. Terms and definitions that have already been defined in the Code of Federal Regulations must not be used until after legislative changes have been made. Veterans Affairs and the Department of Defense continue to work on reaching consensus for additional terms and definitions that impact the wounded, ill, and injured servicemember and veteran.

Proposed terms and definitions for major life activities, mental disorder, recovering servicemember, and serious illness or injury will require legislation.

Attached is a copy of the signed agreement and the agreed upon definitions.



**DoD/VA WOUNDED, ILL, AND INJURED
SENIOR OVERSIGHT COMMITTEE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301**



DEC 10 2008

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
UNDERSECRETARY FOR HEALTH (VETERANS
HEALTH ADMINISTRATION)
UNDERSECRETARY FOR BENEFITS (VETERANS
BENEFITS ADMINISTRATION)
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
GENERAL COUNSEL OF THE DEPARTMENT OF
DEFENSE

SUBJECT: Implementation of Wounded, Ill and Injured-Related Standard Definitions

References: (a) Section 1602 of Public Law 110-181, "National Defense Authorization
Act for Fiscal Year 2008", January 28, 2008
(b) Veterans' Disability Benefits Commission Final Report, August 2007

The Overarching Integrated Product Team (OIPT) approved 33 Wounded, Ill and
Injured (WII)-related standard terms and definitions which are presented in the
attachment.

This memorandum directs the use of these standard terms and definitions for all
WII-related reports, requests for information, data calls, communications, and
collaborative efforts between the Department of Defense (DoD) and the Department of
Veteran's Affairs (VA) not later than December 15, 2008. Terms that have already been
defined in the Code of Federal Regulations are annotated with a reminder that the
proposed definitions must not be used until after legislative changes have been made.

P.W. Dunne
Co-Chair, VA
Wounded, Ill and Injured
Overarching Integrated Product Team

Michael L. Dominguez
Co-Chair, DoD
Wounded, Ill and Injured
Overarching Integrated Product Team

cc:

Assistant Secretaries of the Military Departments

Assistant Secretary of Defense (Health Affairs)

Assistant Secretary of Defense (Reserve Affairs)

Executive Director Wounded, Ill, and Injured Senior Oversight Committee

Senior Oversight Committee Line of Action Co-Leads

Surgeons General of the Military Departments

APPROVED WOUNDED, ILL AND INJURED-RELATED DEFINITIONS

1. **CATASTROPHIC INJURY/ILLNESS.** A permanent, severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that a Service Member or Veteran (SM/V) requires personal or mechanical assistance to leave home or bed, or requires constant supervision to avoid physical harm to self or others.

2. **COMBAT RELATED DISABILITY.** A disability that has been determined by DoD as being attributable to an injury for which the member was awarded the Purple Heart; or was incurred (as determined under criteria prescribed by the Secretary of Defense):

- As a direct result of armed conflict
- While engaged in hazardous service
- In the performance of duty under conditions simulating war
- Through an instrumentality of war

3. **COMBAT RELATED WOUNDED WARRIOR.** A term referring to the entire population of WWII SM/Vs who incurred a wound, illness, or injury for which the member was awarded the Purple Heart or whose wound, illness, or injury was incurred:

- As a direct result of armed conflict or
- While engaged in hazardous service or
- In the performance of duty under conditions simulating war, or
- Through an instrumentality of war

4. **COMMITTED DESIGNEE.** Any person legally designated by the SM/V (or, if the SM/V is unable, by other legal authority, such as a court or the Military Department) who provides support, deemed necessary by medical authority, to the seriously injured or ill SM/V following the occurrence of wound or injury or onset of illness, to his/her recovery. These might include parents, siblings, fiancées, other family members, or close friends.

Committed Designees must demonstrate his/her commitment to serving in that role by incurring financial expense(s) or loss(es) (e.g. taking a leave of absence from work to support the member, making an unplanned move to the member's location of treatment, providing no-cost room and board to the member during or after recovery, providing caregiver services to the member).

5. **COMPENSABLE COMBAT RELATED DISABILITY.** A disability that is compensable under the laws administered by the Secretary of Veterans Affairs that has been determined by DoD as being attributable to an injury for which the member was awarded the Purple Heart or was incurred (as determined under criteria prescribed by the Secretary of Defense):

- As a direct result of armed conflict
- While engaged in hazardous service
- In the performance of duty under conditions simulating war
- Through an instrumentality of war.

- systemic barriers to care and services are resolved at both the individual and the system level.

11. **INCAPACITATING ILLNESS OR INJURY.** The casualty status of a person whose illness or injury requires hospitalization but medical authority does not classify as very seriously ill or injured or seriously ill or injured and the illness or injury makes the person physically or mentally unable to communicate.

12. **INJURED.** Injured means suffering from any intentional or unintentional physical trauma, psychological trauma, distress, or damage to the body resulting from acute or chronic exposure to thermal, mechanical, or electrical energy; or to toxic, biological, or chemical agents; or from the absence of such essentials as heat or oxygen.

13. **MAJOR LIFE ACTIVITIES.** (Major life activities are currently defined in CFR 199.2b and PL 109-13, Section 1032 as “Breathing, cognition, hearing, seeing, and age appropriate ability essential to bathing, dressing, eating, grooming, speaking, stair use, toilet use, transferring and walking.” The following proposed definition must not be used until required legislative changes have been made.)

MAJOR LIFE ACTIVITIES (Proposed definition). Major life activities include the following:

- a) basic daily living skills (e.g., eating, bathing, dressing)
- b) instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication), and
- c) functioning in social, family, and vocational/educational contexts

14. **MEDICAL CARE CASE MANAGEMENT.** Medical care (clinical) case management is a collaborative process under the population health continuum which assesses, advocates, plans, implements, coordinates, monitors, and evaluates options and services required to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. Health is defined by the World Health Organization as: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

15. **MEDICAL TREATMENT.** Medical treatment is any medical practice(s) or procedure(s) (that is not investigational) performed by health care/medical professionals on a wounded, ill, or injured Service member/veteran for the purposes of health-preservation/restoration.

16. **MENTAL DISORDER.** (Mental disorder is currently defined in CFR 199.2b as “For the purposes of the payment of CHAMPUS benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient’s ability to function in one or more major life activities. Additionally, the mental disorder must be one of those conditions listed in the DSM-III.” The following proposed definition must not be used until required legislative changes have been made.)

MENTAL DISORDER (Proposed definition). A mental disorder that is represented by one of the diagnoses listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatric Association. Note that "V codes" represent situations that are not mental disorders. Unless otherwise specified, the terms psychological disorder and behavioral disorder have the same meaning as mental disorder.

17. **MENTAL HEALTH STATUS.** A person's overall emotional and psychological condition (American Heritage Dictionary, 2008, definition #3), characterized by the absence of or presence of psychological condition or disorder, with or without the need of medication.

18. **NON-MEDICAL ATTENDEE.** A designated individual or someone with a personal relationship to a WII SM/V who helps take care of the member or veteran, and whose presence may contribute to the SM/V's health and welfare, as determined by the attending physician or surgeon and commander or head of the military medical facility exercising control over the member.

19. **NON-MEDICAL CARE MANAGER.** The Non-Medical Care Manager will ensure the recovering service member and family get all the non-medical support they need. The NDAA defines their role as:

- Communicating with the service member and with the SM's family or other individuals designated by the service member regarding non-medical matters that arise during the care, recovery, and transition of the service member
- Assisting with oversight of the service member's welfare and quality of life
- Assisting the service member in resolving problems involving financial, administrative, personnel, transitional, and other matters that arise during the care, recovery, and transition of the service member.

20. **NOT SERIOUSLY ILL OR INJURED.** The casualty status of a person whose illness or injury requires medical attention may or may not require hospitalization, and medical authority classifies as less severe than Seriously Injured or Ill.

21. **OUTPATIENT.** Use of a health care facility for diagnosis or treatment without being admitted to a hospital or other authorized institution as an inpatient. Sometimes called a day patient.

In-out [ambulatory] surgery. Surgery performed in the outpatient department of a hospital or other institutional provider, in a physician's office or the office of another individual professional provider, in a clinic, or in a "freestanding" ambulatory surgical center which does not involve a formal inpatient admission for a period of 24 hours or more. - 32 CFR 199.2(b)

22. **RECOVERY CARE.** All activity involved in the management, treatment, transition, and rehabilitation of the WII SM/V toward reintegration.

23. **RECOVERY CARE COORDINATOR.** An individual assigned by the government to recovering SMs whose duties shall include overseeing and assisting the SM as they process

through the entire spectrum of care, management, transition, and rehabilitation services available from the Federal Government, including services provided by the DoD, the VA, the Department of Labor, and the Social Security Administration.

24. RECOVERING SERVICE MEMBER. (Recovering Service Member is currently defined in NDAA 2008 as “The term “recovering service member” means a member of the Armed Forces including a member of the National Guard or a Reserve, who is undergoing medical treatment, recuperation, or therapy and is in an outpatient status while recovering from a serious injury or illness related to the member’s military service. The following proposed definition must not be used until required legislative changes have been made.)

RECOVERING SERVICE MEMBER (Proposed Definition). Recovering Service member is a term used for a member of the Uniformed Services who is undergoing medical treatment, recuperation, or therapy and is in an inpatient or outpatient status, who incurred or aggravated a serious illness or injury in the line of duty, and may be assigned to a temporary disability retirement or permanent disability retirement list due to the disability evaluation system proceedings.

25. RECUPERATION. Recuperation is the healing of an individual following wound, injury or illness.

26. REHABILITATION. The process of enabling achievement and maintenance of optimal physical, sensory, intellectual, psychological, occupational, and/or social functional levels

27. REINTEGRATION. Reintegration consists of educational events, referrals, and proactive outreach activities for all military personnel including the National Guard and Reserve Component members, the WII SMs and retired members of the Uniformed Services, their families, and associated community members to enable access to services supporting their transition from the deployment cycle to routine civilian life or return to military duty, from medical care to rehabilitation, and sustainment through other meaningful employment activities.

28. SERIOUS ILLNESS OR INJURY (NDAA 2008). (Serious Illness or Injury is currently defined in NDAA 2008 as “The term “serious illness or injury” in the case of a member of the Armed Forces, including a member of the National Guard or Reserves, means an injury or illness incurred by the member in the line of duty on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member’s office, grade, rank or rating.” The following proposed definition must not be used until required legislative changes have been made.)

SERIOUS ILLNESS OR INJURY (Proposed Definition). The term “serious illness or injury” in the case of a member of the Armed Forces, including a member of the National Guard or Reserves, means an injury or illness incurred by the member in the line of duty in the Armed Forces that may render the member medically unfit to perform the duties of the member’s office, grade, rank or rating.

29. SERIOUSLY ILL OR INJURED. The casualty status of a person who has: an injury; a physiological or psychological disease or condition; or a mental disorder that requires medical

attention and medical authority declares that the condition is life-threatening or life-altering, and/or that death is possible, but not likely within 72 hours. This may include Post Traumatic Stress Disorder and associated conditions as deemed by medical authority to be life-threatening or life-altering and/or that death is possible but not likely within 72 hours. NOTE: A casualty status is assigned at a specific point in time and could be changed.

30. TRANSITION. In the context of leaving military service, this term is defined as follows: For Active Duty members, it includes discharge, separation or retirement. For Reserve and Guard members, it includes being released from Active or Reserve duty as well as discharge, separation or retirement. The release may or may not be for medical reasons. It includes the assimilation back into a civilian way of life.

31. VERY SERIOUSLY ILL OR INJURED. The casualty status of a person whose illness or injury is such that a medical authority declares it more likely than not that death will occur within 72 hours.

32. WOUNDED. A SM/V who has incurred an injury as a result of an attack or other use of force against the US, US forces, or other designated persons or property. It also includes force used directly to preclude or impede the mission and/or duties of US forces, including the recovery of US personnel or vital US Government property. It also includes a person who was injured mistakenly or accidentally by friendly forces actively engaged with the enemy, who are directing fire at a hostile force or what is thought to be a hostile force.

33. WOUNDED WARRIOR. A term in popular use typically referring to the entire population of wounded, ill, and injured SM/Vs.

Mr. DIMSDALE. I don't want to send you a woof ticket. I want to get something straight.

Senator GRAHAM. I got you. Thank you for participating and serving our Nation.

Mr. DIMSDALE. Thank you.

Senator BEN NELSON. Thank you, Senator. Senator Hagan?

Senator HAGAN. Thank you, Mr. Chairman. I can understand how confusing this would be for the men and women in the Service who obviously, once they're veterans, they've all been in DOD or the Reserves or the National Guard. Then it seems like they're in a different language and a different world going into VA. I think this committee is excellent, and I certainly think it is time that we try to mesh the two in a seamless fashion.

Dr. Guice, I think you were talking a little bit, too, about some of the case manager aspects, and I know that Lieutenant Kinard said that he had eight different case managers. So these pilot programs you're doing now, is that actually going to solve those issues?

Dr. GUICE. The term "case manager" is a fairly ubiquitous and generic term. It is a term used to describe any organization service delivery system. You have case managers in the legal system. You have case managers in public assistance programs. You have case managers in healthcare. In healthcare, case managers are usually aligned with a service line or a specialty, but they exist within a single facility; for example, in a hospital or in an outpatient unit of a hospital. They are very key in actually organizing the individual's care in that facility.

When the individual moves to another facility—for example, if you're at WRAMC and you go down to the polytrauma unit in Tampa, you would have another set of case managers similarly aligned because of your constellation of injuries.

Having a care coordinator eases that transition. The care coordinator in the FRCP, for example, will stay with that servicemember and family when they transition over to the VA polytrauma unit, and then when they transition back, and however many transitions they need to make it through the medical system because specialized care occurs in a variety of different places.

Care coordinators can help connect the dots for the individual, making sure that all the case managers are aware of any particular needs of that individual or family, and making sure it is as comfortable a transition as possible. Transitions are always difficult, but the coordination effort reduces the challenges veterans, servicemembers, and caregivers face.

Senator HAGAN. Do we have enough personnel to do the care coordinator model?

Dr. GUICE. I believe we do. I think it is under continuous evaluation, it may change tomorrow, depending upon what happens. It is always something that we are constantly looking at, recalibrating, and adjusting.

Senator HAGAN. Great. Then this is a follow-up to Senator Graham's question, but I really think that keeping our wounded warriors employed is critical, if they can be. Obviously, if it's a catastrophic injury, in many cases, they cannot.

But I encourage the Services to devise road maps to enable our wounded warriors with additional skill sets, with the transition into civilian life, or perhaps the Services could utilize them in another capacity, keeping them on duty.

These wounded warriors, if they could be trained to serve as administrative personnel, be assigned as case managers, be assigned as mentors to other wounded warriors. I was just curious as to what are your thoughts on this, and is this being done?

General MEURLIN. It is. On the first point that Senator Graham mentioned on Lieutenant Colonel Gadson being retained in the Service as a double amputee. In the Air Force, we had, a number of years ago, the first amputee above the knee who's flying. He's a pilot with the 89th and back on flying status. We've made a huge change in how we look at injuries.

Part of the RCC program, this is a group that's administered by DOD that does the care management that Dr. Guice was talking about, and developing the comprehensive recovery plan for the individual, looks at where that individual wants to go, what his ultimate destination is, or hers, and then programs it along. We work with the Department of Labor. We work with VA. We work with the Services to see how they can be retained if they want to or how they want to transition.

There are a number of programs out there. We've been working with one in the very infant stages now of training people to work within the Civil Service, actually leading them and training them while they're in that recuperative time to ultimately be employable. All of this, and this larger package gets taken care of or coordinated by the RCC or the FRCC to facilitate that smooth transition.

Senator HAGAN. Thank you. Thank you, Mr. Chairman.

Senator BEN NELSON. Thank you, Senator. Thank you to all the panels for your candid and heartfelt testimony today. The journey has thus far been a long one, but we recognize that we're not at the conclusion of it yet. Even when we get to the conclusion, there will be a need to continue to work together to make certain that the integrated system continues to work forward. Thank you very much.

The written testimony submitted by all witnesses today will be included in the record, without objection. Additionally, we received a statement from the Blind Veterans Association, and without objection, it too will be included in the record of this hearing.

[The prepared statement of Dr. Zampieri follows:]

PREPARED STATEMENT BY DR. THOMAS ZAMPIERI, PH.D.

INTRODUCTION

Chairman Nelson, Ranking Member Graham, and members of the Senate Armed Services Subcommittee on Personnel, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to submit our testimony for the record regarding the lack of progress on the implementation of the Wounded Warrior section 1623 of the National Defense Authorization Act (NDAA) for Fiscal Year 2008 to establish a program for the large numbers of military vision injured. BVA was established in 1945, and congressionally chartered in 1958, as the only Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families, and BVA finds the bureaucratic problems associated with the slow implementation of the congressionally mandated NDAA Vision Center of Excellence section 1623, today demands more oversight by this committee and more direct questions today. The NDAA section 1623 required establishment of the joint Department of Defense (DOD) and Department of Veterans Affairs (VA) Vision Center of Excellence (VCE) and Eye Trauma Registry.

On March 17, 2009, three Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) seriously eye injured veterans recently testified and shared stories before the House VA subcommittee on Oversight and Investigations hearing on how there was and still is no Seamless Transition program for them between DOD medical treatment facilities and VA medical centers. Despite a dedicated working group of senior military and VA ophthalmologist and optometry professionals working since November 2007, with specific plans for how the joint Vision Center of Excellence should be established and operate, for 14 months there has been a lack of administrative support, failure to approve organizational charter until February 2009, and according to several senior DOD sources a persistent funding challenge to establish this VCE. When asked how much has been spent on the Vision Center of Excellence since October 2008 at the House VA Oversight hearing the response was incredible low total of "DOD has spent \$7,000 for the Vision Center of Excellence" and it was not until March 12, 2009 that a letter was sent to Chairman Mitchell on the VA Oversight Subcommittee that \$3 million had been identified for the VCE 13 months after congress required the establishment of the VCE.

OBSTACLES TO VCE IMPLEMENTATION

OIF and OEF servicemembers with both penetrating eye trauma and Traumatic Brain Injury (TBI) visual impairment have had to wade through a DOD bureaucracy. DOD has given us the impression that, for them, an entire year's time to create an organizational charter is actually not that long. Persistent excuses for lack of action range from "no plan was approved for VCE" to, of course, "no funding has been found to create VCE."

When NDAA was enacted in January 2008, an immediate reaction from some senior level Assistant Secretary of Defense for Health Affairs officials was that VCE was an "unfunded mandate by Congress" that would cost "an estimated \$5 million that we do not have built into this fiscal year 2008 year's budget." If this were the case, questions should be asked at Pentagon, "Why were these funds not requested in either last year's May 2008 War Supplemental (H.R. 2462) when \$162 billion" was provided for, among other things, "wounded warrior care" or, better yet, in the fiscal year 2009 Defense Appropriations request to cover this fiscal year 2009 year's start-up costs. Instead, on April 12, in early June, and again in early August at the

Skyline Drive office of the Assistant Secretary of Defense for Health, then once again on September 24, senior officials repeated the claim that finding even the bare minimum of \$3 million to fund start-up costs for the Vision Center of Excellence VCE presented a very significant funding challenge.

For 4 years, BVA has attempted to bring to the attention of the Armed Services Committees, the Defense Appropriations Committees, both VA Committees, DOD Health Affairs, and the Veterans Health Administration (VHA) the ever-increasing prevalence of combat eye trauma and TBI visual dysfunction among servicemembers. We have become increasingly concerned about the growing numbers of both the battle wounded who have penetrating direct eye trauma (13 percent of all evacuated wounded have experienced eye trauma) and/or TBI-related visual complications (64 percent with TBI have tested positive for visual dysfunction).

Responses to these pleas have included "the need to wait until the next plan is approved," "NDAA reports come late for review," "inability to find office space," and the aforementioned "lack of funding." The cumulative result of these responses has been delayed action, scarce resources for establishment of the VCE, no dedicated space, no request for funding for staffing or construction even today while witnesses testify before your committee.

The Pentagon did appoint the first Director of VCE in November 2008. Colonel Donald Gagliano is a highly qualified and dedicated 29-year Army career ophthalmologist who served in Iraq for 1 year. Also appointed was an equally well-qualified VA Deputy Director of VCE, Dr. Claude Cowan with distinguished career in ophthalmology research, education, and clinical practice here in Washington DC VA medical center. BVA fully supported both of these appointments. The two directors of the VCE have entered these challenging positions with virtually no office space, little staffing support, funding for 3 months of \$7,000, no organizational charter until February 2009, and thousands of combat eye-wounded servicemembers and veterans spread across various military medical facilities and VA medical centers. Thanks to MILCON/VA Appropriations Chairman Chet Edwards, VA received a \$2 million appropriation for IT Registry support for fiscal year 2009. Although Senate MILCON/VA Appropriations Chairman Tim Johnson also helped provide an additional \$6.9 million to VHA, questions persisted for months regarding a plan on how to use these funds because of lack of implementation of the VCE within DOD.

The OIF and OEF eye wounded who have recently enrolled in the VA health care and benefits system never should have encountered this difficult process. Quick action by Secretary Gates, in cooperation with Secretary Shinseki and with the full attention of the Senior Oversight Committee, is now vital to correct this mess and these witnesses must explain why this process has been delayed.

BVA emphasizes that the clinical skills of the DOD professional eye care providers, both ophthalmology and optometry, have been excellent. In many cases, they have been no less than outstanding. Ophthalmology surgery not possible during previous wars has saved the vision of many soldiers and marines. Nevertheless, the system that organizes and administers such treatment must become accountable for all battle eye wounded and TBI patients affected. It must answer for the lack of action inherent in its failure to begin staffing procedures that will eventually reach 12 positions, failure to locate office space, and failure to address the issue of construction renovation funding for the National Naval Medical Center.

PREVALENCE AND INCIDENCE OF VISUAL IMPAIRMENTS

As of September 2008, VHA reported 8,747 diagnoses of TBI with approximately 7,500 in diagnostic testing for possible TBI. Improvised Explosive Device (IED) blasts contributed to more than 60 percent of these injuries. As of January 30, 2009, a total of 33,993 servicemembers had been wounded or injured by accidents in Iraq. The number of those wounded in hostile operations and requiring air medical evacuation from Iraq between March 19, 2003, and January 30, 2009, from one early report was 9,375, of which an estimated 13 percent (1,219) had sustained combat penetrating eye trauma. Some 135 of this number blinded have enrolled in VA Blind Rehabilitation Service (BRS) programs. This past November, however, the Military Surveillance Monthly Report contained an article from DOD on eye injuries among members of Active components (U.S. Armed Forces, 1998–2008) that detailed, by ICD, diagnostic code searches turning up 4,970 perforating and penetrating eye trauma cases, 4,294 chemical or thermal burns, and 686 damaged optic nerves, most of which were from among OIF and OEF injured.

The number of direct battle eye injuries does not include estimates of all moderate-to-severe TBI servicemembers or veterans who have visual dysfunction, according to VA research of those tested by either neuro-ophthalmologists or low-vision optometrists at a few military and VA centers. We stress that while only a

small percentage of the eye injured meet the legal blindness definition of 20/200 or less of visual acuity, those with neurological vision dysfunction from mild, moderate, or severe TBI will require long-term VA eye care follow-up in low-vision clinics. Veterans with a history of ocular battle injuries are also at high risk of developing retinal detachments, traumatic cataracts, glaucoma, and other delayed TBI neuro-visual complications that can occur years after the initial injury.

The top three contributors to combat eye injuries have been Improvised Explosive Devices (IEDs), Rocket-Propelled Grenades (RPGs), and Mortars, with IEDs causing 56.5 percent of all eye injuries in Iraq. Just how many servicemembers have actually sustained moderate-to-severe TBI injuries to the extent that they are experiencing neuro-sensory visual complications is anyone's guess. The estimates in professional journals and other publications indeed change from month to month. The 64 percent figure (those with TBI who have experienced visual dysfunction) represent those with associated neurological visual disorders of diplopia, convergence disorder, photophobia, ocular-motor dysfunction, color vision loss, and an inability to interpret print. Some TBIs result in visual field defects with enough field loss to meet legal blindness standards. We are also finding ever increasing numbers of TBI-caused "functionally blinded" OIF and OEF veterans who, while not legally blind, are unable to perform normal daily activities because of loss of vision. More TBI visual screening, diagnosis, treatment, and new outcome studies should be initiated without delay.

One early VA research study (2005) of OIF and OEF servicemembers who had entered the VA system with an ICD-9 (diagnostic code) search found 7,842 individuals with a traumatic injury of some kind. Consistent with recent media articles and VA reports, the most common traumatic injury diagnoses were hearing loss and tinnitus (63.5 percent). We now know that 94,191 of the more than 1.5 million troops who have served in OIF and OEF are now service-connected for tinnitus while 78,076 are service-connected for hearing loss. A major cause of this hearing loss (60 percent of the cases) is exposure to IEDs. The second most common VA diagnostic code was for visual impairment (27.9 percent). We submit to this subcommittee that the cases of sensory loss of hearing and visual impairment as a result of TBI constitute has been a "the sensory silent epidemic" not widely reported by DOD or the media. They are, nevertheless, the #1 hearing loss, and #2 vision injuries from OIF and OEF combat injuries.

NEUROLOGICAL IMPACT OF TBI DYSFUNCTION

Perception plays a major role in an individual's ability to live life. Although all senses play a significant role in perception, the visual system is critical to perception, providing more than 70 percent of human sensory awareness. With hearing being another critical component, IED blast injuries can obviously impair markedly these two key sensory systems.

Vision provides information about environmental properties. It allows individuals to act in relation to such properties. In other words, perceptions allow humans to experience their environment and live within it. Individuals perceive what is in their environment by a filtered process that occurs through a complex, neurological visual system. With various degrees of visual loss comes greater difficulty to clearly adjust and see the environment, resulting in increased risk of injuries, loss of functional ability, and unemployment. Impairments range from loss in the visual field, visual acuity changes, loss of color vision, light sensitivity (photophobia), and loss of the ability to read and recognize facial expressions.

Although one can acquire visual deficits in numerous ways, one leading cause is injury to the brain. Damage to various parts of the brain can lead to specific visual deficits. Some cases have reported a spontaneous recovery but complete recovery is unlikely and early intervention is critical. Current complex neuro-visual research is being examined in an attempt to improve the likelihood of recovery. Nevertheless, the extent of the recovery is often limited and will usually require long-term follow-up with specialized adaptive devices and prescriptive equipment.

The brain is the most intricate organ in the human body. The visual pathways within the brain are also complex, characterized by an estimated two million synaptic connections. About 30 percent of the neocortex is involved in processing vision. Due to the interconnections between the brain and the visual system, damage to the brain can bring about various cerebral visual disorders. The visual cortex has its own specialized organization, causing the likelihood of specific visual disorders if damaged. The back of head, the occipitotemporal area of the brain is connected with the "what" pathway. Thus, injury to this ventral pathway leading to the temporal area of the brain is expected to affect the processing of shape and color. This can make perceiving and identifying objects difficult. The occipitoparietal area (pos-

terior portion of the head), is relative to the “where,” or “action” pathway. Injury to this dorsal pathway leading to the parietal lobe will increase the likelihood of difficulties in position (depth perception) and/or spatial relationships. In cases of injury, individuals find it hard to determine an object’s location and may also discover impaired visual navigation.

It is highly unlikely that a person with TBI will have only one visual deficit. A combination of such deficits usually exists due to the complexity of the organization between the visual pathway and the brain. The most common cerebral visual disorder after brain injury involves visual field loss. The loss of peripheral vision can be mild to severe and requires specific visual field testing to be correctly diagnosed. In turn, a number of prescribed devices are frequently necessary to adapt to this loss.

Accompanying such complex neurological effects on the patient is the overwhelming emotional impact of brain injury on the patient and his/her family. BVA would ask the Senate Armed Services Committee members to seriously consider the ramifications of such visual injuries. Brain injuries are known for causing extreme distress on family members who must take on the role of caregivers. According to a New England Journal of Medicine report of January 30, 2008, TBI “tripled the risk of PTSD, with 43.9 percent of those diagnosed with TBI also afflicted with PTSD.”

At present, the current system of screening, treatment, tracking, and follow-up care for TBI vision dysfunction is inadequate across the systems. Adding visual dysfunction to this complex mix of other physical and mental injuries, especially if undiagnosed, makes attempts at rehabilitation even more daunting and potentially disastrous unless there are significant improvements in the screening, treatment, tracking, and follow-up care through the proposed and legislated Vision Center of Excellence.

VCE TO ADDRESS CRITICAL ISSUES

BVA believes that the VCE Eye Trauma Registry is where vital components for research, best practices, outcome measures, and education can be developed and refined for the eye trauma wounded and those with TBI vision dysfunction. Critical vision research coordinated with the Defense Veterans Brain Injury Centers and Defense Centers of Excellence for TBI can facilitate effective eye trauma research between DOD and VA. We predict that the number of TBI-injured will again increase beginning this spring as the troop surge into Afghanistan gets underway.

BVA wishes to clear up false misinformation about VCE that has recently become commonplace: First, VCE is not to be one large clinical eye treatment center for all combat eye injured. It is better understood as “a virtual center with connectivity” to the four major military trauma centers identified last June in testimony before VA Committee as (Bethesda National Naval Medical Center, Brooke Army Medical Center, Madigan Army Medical Center, and San Diego Naval Medical Center), the soon-to-be five VA Polytrauma Centers. The VCE will connect there and the hundreds of other military or VA medical centers where the highest proportion of eye-injured and TBI-wounded are already receiving specialized eye surgery care and low-vision optometric services.

Second, VCE is not a DOD blind center or rehabilitation facility. It will, however, coordinate its work with the already existing, skilled, multidisciplinary VA Blind Rehabilitation Centers (BRCs) and low-vision clinics with decades of experience treating blinded veterans. The VCE Eye Trauma Registry will track all eye injured and TBI visually impaired, coordinate joint vision research, promote best practices, and develop educational information on vision services for both providers and families.

VA BRS AND LOW-VISION SERVICES

A positive note is that the challenges inherent in the growing number of returning OIF and OEF servicemembers needing screening, diagnosis, treatment, and a coordinated Seamless Transition of services can be met by the existence of world-class VA BRCs. The programs provided at such centers now have a 60-year history. In the larger picture of VA programs for blind and visually impaired veterans, BVA began working more than 4 years ago to ensure that VA expand its current capacity to serve blinded veterans. Such expansion became necessary as the aging population of veterans with degenerative eye diseases requiring specialized services has continued to increase.

As a result of efforts to broaden and increase services, 54 new outpatient intermediate low-vision and advanced blind rehabilitation outpatient programs already have specialized staffing in place. Many of these new programs are opening with

veteran-centered, low-vision specialized teams providing the full range of basic, intermediate, and advanced rehabilitation services. Accompanying these gains is special VA emphasis on outcome measurements and research projects within VHA. The VA approach of coordinated team methods for rehabilitation care has unlocked strategies for new treatments and provided the most updated adaptive technology for blinded veterans. The new, specialized low-vision and blind programs already existing within the VA system must be utilized by DOD through VCE. The eye injured must receive high quality health care with proven outcomes that include constantly emerging vision research.

The mission of each Visual Impairment Services Team (VIST) program is to provide blinded veterans with the highest quality of vision loss services and blind rehabilitation training that truly help them adjust to the major changes they have experienced in their lives. To accomplish this mission, VISTs have established mechanisms to facilitate more completely the identification of blinded veterans and to offer a review of benefits and services for which they are eligible. The VIST concept was created in order to coordinate the delivery of comprehensive medical and rehabilitation services for blinded veterans. VIST Coordinators can assist not only newly blinded veterans with timely and vital information leading to psychosocial adjustment, but can also provide similar assistance to their families.

Seamless Transition from DOD to VA is best achieved through the dedicated work of VIST Coordinators and Blind Rehabilitation Outpatient Specialists (BROS) but many DOD case managers are unaware of these key contacts. They are in a unique position to provide comprehensive case management services to returning OIF/OEF service personnel for the remainder of their lives if consulted. VIST Coordinators are now following the progress of 135 recently OIF or OEF blinded veterans who are being served on an outpatient basis and 585 low vision veterans. The VIST system currently employs 112 full-time and 43 part-time Coordinators. There are 39 full-time BROS/VIST teams who also manage these cases and VA is process of recruiting another 28 BROS for these clinics for veterans.

The VA BROS is a highly qualified professional. Many BROS hold Masters Degrees in both Orientation and Mobility and Rehabilitation Teaching. BROS also receive extensive cross-training at 1 of the 10 BRCs nationwide. The training prepares such individuals to provide, in the veteran's home environment, the full range of mobility, living, adaptive, manual, and other skills essential to blind rehabilitation. VIST/BROS teams are also well equipped to provide excellent local services on a continuing basis when a veteran returns home from an inpatient stay at a BRC.

Advanced Outpatient Rehabilitation Programs occur in "Hoptel" settings, as VA calls them. Hoptel sleeping arrangements function perhaps more like hotels than hospitals. Such programs offer Skills Training, Orientation and Mobility, and Low-Vision Therapy for veterans who need treatment with prescribed eye wear, magnification devices, and adaptive technology to enhance remaining vision.

A VIST Coordinator manages the blind programs with other key staff consisting of certified BROS, Rehabilitation Teachers, Low-Vision Therapists, and a part-time Low-Vision Ophthalmologist or Optometrist. Medical, surgery, psychiatry, neurology, rehabilitative medicine, pharmacy, physical therapy, and prosthetics services can all be consulted as needed within the VA Medical Center, effectively providing the full continuum of care for the OIF and OEF veterans. DOD and VA are in the process of developing a bi-directional electronic eye trauma Registry that exchanges eye surgery records and clinical eye examinations case information. BVA warns that Private agencies that offer blind rehabilitation would rarely have full on site consultative medical services, surgical subspecialties, and psychiatry all co-located within one facility, meaning veterans and their families would have to travel additional distances to obtain needed outpatient care for other conditions, adding to wait times for consultants, delays in obtaining prescribed medications, or waiting on new treatment plans and disrupting critical training time for orientation or mobility blind training. BVA strongly recommends that private agencies utilized for any services provide evidence of peer reviewed outcome studies, quality assurance standards, research experience, and information technology systems that can exchange records to VA system. We also recommend that they be accredited by the Commission on Accreditation of Rehabilitation Facilities CAW, that they are required to utilize VA electronic health care records for clinical standards of care, and that they meet specific outcome measures for contracts.

Another important model of service delivery that does not fall under VA BRS is the VICTORS program, or the Visual Impairment Center to Optimize Remaining Sight. VICTORS is an innovative program that has been operated by VA Optometry Service for more than 18 years. The program consists of specialized services to low-vision veterans who, though not legally blind, suffer from visual impairments. Veterans must generally have a visual acuity of 20/70 through 20/200 to be considered

for VICTORS. The program, entirely outpatient, typically lasts 3–5 days. Veterans undergo a comprehensive, low-vision optometric evaluation. They receive prescribed low-vision devices and are trained in the use of adaptive technology to optimize functional independence.

The Low-Vision Optometrists employed in the Intermediate Low-Vision programs are ideal for the highly specialized skills necessary for the assessment, diagnosis, treatment, and coordination of services for Iraq and Afghanistan returnees with TBI visual symptoms. This is because such veterans often require long-term follow-up services. The programs also assist the aging population of veterans with degenerative eye diseases. Such programs often enable working individuals to maintain their employment and retain full independence in their lives. They also provide testing for and research into the effectiveness of adaptive low-vision technology aids that have recently become available through training, review, and research. In conjunction with a wide network of VA eye care clinics existing in VA medical centers nationwide, combined VIST/BROS teams and Intermediate/Advanced Outpatient programs can provide a wide network of specialized services for these OIF and OEF veterans and their families once the VCE is fully operational.

These new VA Advanced and Intermediate rehabilitative low vision or blind outpatient programs, are cost effective for high-need, low-vision OIF/OEF veterans with residual vision from TBI. Combined VIST/BROS teams and Intermediate/Advanced Outpatient programs can provide a wide network of specialized services for servicemembers and their families in coordination with existing VA Eye Care clinics within VA medical centers. VCE is critical to the success of all of the aforementioned specialized VA services.

CONCLUSIONS

Serious combat eye trauma and visual dysfunction associated with TBI among OIF and OEF service personnel have become the second most common injury resulting from the two conflicts. More than 9,940 visual injuries have occurred and unknown thousands more have TBI visual dysfunction stemming from TBI if Rand Study projections are correct. We urge members of the full Senate Armed Services Committee to demand compliance with the existing NDAA requirements. DOD should have either requested from congress, or provided the \$5 million funding for the remainder of fiscal year 2009 from the War Supplemental, for joint professional and administrative staffing, office space renovation funds, information technology funding, and the Senior Oversight Committee should have coordinated and complied with all congressionally directed activities established in section 1623 Vision Center of Excellence and Eye Trauma Registry. The establishment of the Defense Intrepid Center of Excellence for Mental Health and the TBI Center of Excellence had \$64 million for fiscal year 2009, but the VCE had no directed funding source causing delays and frustration between the two systems. Immediately establishing the VCE would substantially improve the multidisciplinary coordination, treatment, rehabilitation, and research into eye trauma and TBI-related visual impairment experienced by servicemembers and veterans throughout the DOD and VA systems.

BVA again expresses sincere gratitude to this Subcommittee for the opportunity to present our testimony. We hope that you understand the deep sense of frustration we have felt over the course of the 14 months since NDAA established VCE. Simply put, the time for DOD and VA to implement the VCE fully as intended by Congress, is now. With the large numbers of veterans suffering direct eye injury from battle and TBI visual dysfunction, further delay is unacceptable. Because the population of war wounded servicemembers and veterans is widely diverse geographically, it is not appropriate or reasonable that one military or VA medical treatment facility become the one eye clinical center for all eye-wounded servicemembers or for TBI patients with visual dysfunction. Depending on such an idea would be cost prohibitive and delay care for literally thousands of men and women veterans and having the VCE connect those various already existing sites of eye surgery care is critical now.

We request that the Armed Services Committee require that both Secretary Gates and Secretary Shinseki get VCE on track again and comply with all required reports on the implementation of this center within 30 days of this hearing. The Defense Appropriations Committee should ensure in the next War Supplemental later this month that funding be included for the following necessary items as opportunity to add additional directed funding to fix this.

RECOMMENDATIONS

- The Secretary of Defense and Secretary of Veterans Affairs must immediately direct the Senior Oversight Committee Executive Director to implement the organizational structure and staffing for VCE and provide full

DOD/VA clinical/administrative staffing. They must oversee the securing of temporary office space for at least 12 staff members and see that financial resources are in place to begin full implementation of the operations of VCE. Assistant Secretary Defense for Health Affairs should then report back to this committee within 30 days. VHA was provided \$6.9 million in fiscal year 2009 for VCE these funds should be utilized now for at least some of the expenses associated with VCE's establishment.

- The military director of VCE, Colonel Gagliano, and VA Deputy Director Dr. Cowan need immediate administrative staff support, office equipment, travel funding, and educational support resources from both DOD and VHA to implement the new VCE joint program, with no less than \$2,500,000 million to fund the final quarters of fiscal year 2009 in the war supplemental.
- Congressional oversight should ensure that MILCON/VA and Defense Appropriations Chairmen and Ranking Members review budgets for fiscal year 2010 to ensure that they provide no less than \$6.8 million for VCE activities All Program Operational Management initiatives should be funded for fiscal year 2011, fiscal year 2012, and fiscal year 2013 as mandated by the reporting clause in the National Defense Authorization Act of 2009 and reported to this committee within 30 days of this hearing date.
- The information technology Registry will require \$2,000,000 for fiscal year 2009.
- Some \$2,000,000 million is urgently needed to fund Navy Medical Center renovation construction project that will renovate office space and other facilities at National Naval Medical Center in Bethesda, MD, where VCE Headquarters is to be located.
- VCE must be patient and family centered, comprehensively coordinated, and compassionate. All DOD/VA case managers need educational updates on the various VA specialized vision programs for eye trauma and TBI visual dysfunction. Veterans and family members need information on all VA locations of blind services within VA. VIST/BROS teams must be notified early in the treatment process of transfers to their local area of any seriously eye-injured servicemember.
- It should be a virtual center providing real Seamless Transition that ensures electronic bi-directional registry exchange of both inpatient and outpatient eye care clinical records that both DOD and VA eye care staff can update and share with the Veterans Benefits Administration so that benefits for service-connected injuries can be assessed.
- Private agency involvement in the treatment and rehabilitation process should be narrowly limited to those meeting strict accreditation, CARF accreditation, quality educational, and university peer-reviewed medical research criteria. Such agencies should be equipped with multidisciplinary staff support and meet all Health Insurance Portability and Accountability requirements required in existing DOD policy.
- VCE should become involved in the DOD peer-reviewed Congressionally Directed Medical Research Program (CDMRP) in order to encourage additional TBI visual dysfunction research. More eye trauma research in conjunction with DOD, VA, NIH, and universities with VA academic affiliations is desperately needed now. Potential long-term consequences of mild-to-moderate TBI in OIF/OEF veterans are still unknown. Discoveries of such consequences will require new technology and diagnostic research support. BVA, supported by the current Veterans Service Organization Independent Budget, requests \$10 million for CDMRP in fiscal year 2010 as directed vision research.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

Blinded Veterans Association

The BVA does not currently receive any money from a Federal contract or grant. During the past 2 years, BVA has not entered into Federal contracts or grants for any Federal services or governmental programs.

BVA is a 501(c)(3) congressionally chartered, nonprofit membership organization.

Senator BEN NELSON. This hearing is adjourned. Thank you.
[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR E. BENJAMIN NELSON

ELECTRONIC HEALTH RECORDS

1. Senator BEN NELSON. Ms. Melvin, one of the keys to seamless transition between the Department of Defense (DOD) and the Department of Veterans Affairs (VA) health care systems is the ability to share medical records of servicemembers who receive care through both medical systems. The Wounded Warrior Act required the Secretaries of DOD and VA to develop and implement electronic health record systems that would allow for full interoperability of personal health care information by September 30, 2009. What is your assessment of the progress of DOD and VA have made in development of fully interoperable electronic health care record systems?

Ms. MELVIN. DOD and VA have taken important steps toward the development of fully interoperable electronic health care record systems; however they have more to do—not all electronic health information is yet shared. As we have previously reported,¹ the departments have achieved certain levels of interoperability (that is, the ability to share data among health care providers). This includes sharing pharmacy and drug allergy data at the highest level of interoperability—that is, in computable form, a standardized format that a computer application can act on, as well as structured and unstructured data in viewable form. As of January 31, 2009, the departments reported that they were exchanging computable outpatient pharmacy and drug allergy data on over 27,000 shared patients—an increase of about 9,000 patients since June 2008.² Nonetheless, the departments were not sharing all electronic health data, such as immunization records and history, data on exposure to health hazards, and psychological health treatment and care records. In addition, while VA's health data are all captured electronically, information is still captured on paper at many DOD medical facilities.

DOD and VA have indicated that they have plans to further increase health information sharing. In this regard, they have identified the Joint Executive Council Strategic Plan and the DOD/VA Information Interoperability Plan as defining their planned efforts to provide interoperable health records. However, as we testified in March 2009,³ neither plan identified results-oriented (i.e., objective, quantifiable, and measurable) performance goals and measures that are characteristic of effective planning and can be used as a basis to track and assess progress toward the delivery of new interoperable capabilities. Accordingly, we recommended that the departments develop such goals and measures to be used in reporting of interoperability progress.⁴ In the absence of results-oriented goals and performance measures, progress reporting is largely limited to describing activities completed and increases in interoperability over time.

2. Senator BEN NELSON. Ms. Melvin, what are the challenges DOD and VA are facing in the development of interoperable electronic health care records?

Ms. MELVIN. In their development of interoperable electronic health records, DOD and VA face challenges in the areas of performance measurement, standards setting and compliance, and program office operation. These areas are essential to effectively increasing electronic health information sharing. First, as mentioned previously, our March 2009 testimony⁵ noted that the departments' interoperability plans lacked the results-oriented (i.e., objective, quantifiable, and measurable) performance goals and measures that are characteristic of effective planning. Specifically, of 45 objectives and activities identified in the plans,⁶ only 4 were documented in results-oriented terms. Thus, the extent to which the departments' progress could be assessed and reported was limited to reporting on activities completed and increases in data exchanged (e.g., increases in the number of patients for which certain types of data are exchanged). Second, while DOD and VA have agreed on numerous common health information technology standards that allow them to share health data, the departments must also ensure that their health information systems are aligned with national health information technology standards. Any level

¹ GAO, Electronic Health Records: DOD's and VA's Sharing of Information Could Benefit from Improved Management, GAO-09-268 (Washington, DC: Jan. 28, 2009).

² GAO, Information Technology: Challenges Remain for VA's Sharing of Electronic Health Records with DOD, GAO-09-427T (Washington, DC: Mar. 12, 2009).

³ GAO-09-427T.

⁴ GAO-09-268.

⁵ GAO-09-427T.

⁶ The plans are the November 2007 VA/DOD Joint Executive Council Strategic Plan for Fiscal Years 2008–2010 (known as the VA/DOD Joint Strategic Plan) and the September 2008 DOD/VA Information Interoperability Plan (Version 1.0).

of interoperability depends on the use of agreed upon standards to ensure that information can be shared and used. However, Federal standards are still evolving, which could complicate VA's and DOD's efforts to maintain compliance. The need to be consistent with emerging Federal standards adds complexity to the task faced by the two departments of extending their standards efforts to additional types of health information. Third, we noted that the departments had not completed all necessary activities required for the Interagency Program Office to be fully operational. Department officials stated that this office will be crucial in coordinating VA's and DOD's efforts to accelerate their interoperability initiatives. However, the departments have yet to complete key activities to set up the office. For example, they have not yet hired a permanent Director and Deputy Director. Until the departments complete key activities to set up the office, it will not be positioned to be fully functional, or accountable for fulfilling the departments' interoperability plans.

3. Senator BEN NELSON. Ms. Melvin, will DOD and VA be able to achieve the requirement for fully interoperable electronic health care records by September 2009, as required by the Wounded Warrior Act?

Ms. MELVIN. It is uncertain as to whether DOD and VA will achieve fully interoperable electronic health care records by September 30, 2009. Specifically, in order to meet the September 2009 requirement, the departments have identified six objectives to increase their sharing of electronic health information.⁷ However, five of the six objectives are not documented in terms that allow the departments to measure and report their progress toward delivering new capabilities. For example, DOD identified an objective to increase sharing of inpatient discharge summaries with VA; however this objective does not reflect a need to report progress in quantitative terms (e.g., interoperability levels to be provided, locations and types of medical facilities to be included, and number and types of patients for whom data is to be shared). Without measurable objectives, the ability to ensure that the departments are taking the necessary steps to achieve their interoperability goals is limited.

VISION CENTER OF EXCELLENCE

4. Senator BEN NELSON. Ms. McGinn, the Wounded Warrior Act required DOD to establish a Center of Excellence in prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries. How much money has been spent to date in support of this Center of Excellence and what progress has been made to establish the Center?

Ms. MCGINN. DOD is committed to improving the quality of vision care for our wounded warriors and veterans, who deserve the very best for the sacrifices they have made for our Nation. During the past year, Optometry and Ophthalmology Consultants from the DOD and the VA created the plan that laid the foundation for the Vision Center of Excellence (VCE). DOD analyzed and reviewed the necessary requirements and identified \$3 million in funding that was available at the beginning of fiscal year 2009 to commence initial operating activities.

Colonel Donald Gagliano, VCE Executive Director, and Dr. Claude Cowan, VCE Deputy Director, were appointed in November 2008 and have made significant progress in strategic planning to achieve the objectives of the VCE. The VCE leadership have identified primary resource requirements, including personnel, registry, facilities, TDY, equipment, and operational support to appropriately obligate the funding available. \$20,000 has been obligated to date, however, the VCE is expediting the expenditure of the remaining funds as our resource requirements are now clearly defined and we expect to obligate most of the remaining funds by the third quarter of fiscal year 2009.

The VCE has also made significant progress to fulfill its mission to improve the health and quality of life for members of the Armed Forces and veterans through advocacy and leadership in the development of initiatives focused on the prevention, diagnosis, mitigation, treatment, and rehabilitation of disorders of the visual system. The VCE is taking the steps outlined below to ensure members of the armed services and veterans who are visually impaired receive appropriate blind/vision rehabilitation quickly and effectively:

Operations

DOD and VA officials have been meeting since last year to help shape initial operations. They have developed enabling documents, DOD Directive and VCE Charter,

⁷These six objectives are identified in the September 2008 DOD/VA Information Interoperability Plan (Version 1.0).

to establish the Center. The VCE acquired short-term space near TRICARE Management Activity headquarters in Falls Church, VA, to begin initial operations and is working to secure funding for a long-term facility at the Walter Reed Naval Medical Military Campus. This location allows for collaboration and synergies with the vision care providers and patients in the National Capital Region and will allow the VCE to best meet its congressional mandate by being in close proximity to the new National Intrepid Center of Excellence for TBI, the National Eye Institute of the National Institutes of Health (NIH), the Uniformed Services University, and the National Military Advanced Training Center, a facility for the reintegration and rehabilitation of injured servicemembers.

Registry

The Defense and Veterans Eye Injury Registry (DVEIR) will provide data necessary to measure rates of injuries and longitudinal outcomes. This will support the VCE's efforts to ensure the ongoing improvement in care and care processes and to foster consistency of care across the entire continuum of care. Under an initiative led by the VA, an Ophthalmology, Optometry, and Information Technology workgroup from the VA and the DOD has been meeting since March 2008 and has developed a concept of operations for the DVEIR. The concept of operations, already approved by the VA, examines development options and details a recommended approach to implementing the DVEIR. A joint effort is now in place to identify the specific technical requirements for interoperability, develop a strategic plan and outline milestones for implementation of the registry. The VA initiated a Memorandum of Understanding (MOU) with the Joint Theater Trauma Registry for data exchange and they expect to have developed a mutually satisfactory strategy to populate the registry by the end of fiscal year 2009.

Research

Research will also help the VCE accomplish its goals. VCE leadership established research priorities for the congressional Special Interest Vision Research Programs and the congressionally directed Medical Research Program through collaboration with health professionals from the DOD, VA, NIH, Food and Drug Administration, other Federal health entities, and the private sector. Grant funding will be awarded based on those priorities. The VCE will continue to work with DOD, VA, and other outside entities to move research forward and assist those in need.

Outreach

Outreach is central to the VCE mission. VCE staff members will interact with visually impaired warriors and veterans to identify unaddressed needs and help close those gaps. Colonel Gagliano and Dr. Cowan have visited wounded warriors and veterans at Walter Reed Army Medical Center and other vision care centers and listened to their concerns and experiences. The VCE leadership has solicited input from other centers of excellence, related Federal health agencies, multiple vision/veterans advocacy organizations, and affected members of the armed services and veterans for the VCE way ahead. They have participated in numerous meetings and conferences on visual impairment for warriors, including the Defense Centers of Excellence Strategic Planning Summit. To expand the centers' outreach efforts, the VCE Executive Director was appointed as the DOD ex officio member of the NIH National Eye Advisory Council. Additionally, the VCE is coordinating with the VA Blind Rehabilitation Service to establish an MOU.

5. Senator BEN NELSON. Ms. McGinn, is development of the VCE on par with the development of the Centers of Excellence for PH and Traumatic Brain Injury (TBI)? If not, why not?

Ms. MCGINN. The VCE and the Defense Centers of Excellence (DCoE) for PH and TBI have similar missions: to improve the health and quality of life for members of the Armed Forces and veterans. Pentagon surveillance data indicates there are approximately 40,000 veterans that have sustained a TBI from January 2003–March 2009. Due to the number of people affected and a gap in addressing TBI and PH, Congress established the DCoE and appropriated initial funding for the effort in the Fiscal Year 2007 Supplemental Appropriations bill. The DCoE has made significant advances in education, training, research, and treatment.

Some of these TBI injuries result in visual disorders. Visual dysfunction caused by TBI may be difficult to recognize due to the non-specific nature of many of these symptoms. In addition, visual symptoms may be overlooked during routine medical screenings and the onset of visual symptoms can be delayed. In addition to TBI-related visual disorders, the changing military environment and new mechanisms of ocular injury, such as blast exposure, pose new challenges to vision care specialists. These facts contributed to the impetus for creation of the VCE and the DVEIR. The

DOD and VA established the congressionally-directed VCE in recognition of the increased rate of ocular injuries and visual impairment incurred during the Operation Iraqi Freedom and Operation Enduring Freedom conflicts. As a result of collaborative efforts between the VCE and DCoE, initial screening for TBI now includes screening for vision problems, and the DOD and VA are collaborating on the development of clinical guidelines, research priorities, and outreach initiatives. The DVEIR will also help researchers better understand these injuries by longitudinally tracking outcomes. Other information gained through the registry will ensure that affected warriors and veterans are properly diagnosed and treated.

Colonel Donald A. Gagliano, the VCE Director, and Dr. Claude Cowan, the VCE Deputy Director, were selected in November 2008. The DOD allocated \$3 million in fiscal year 2009 for initial operational capabilities of the VCE and the DOD and VA have made significant progress working together to ensure the VCE is fully operational in the shortest amount of time to assist our warriors and veterans. The advanced development of the DCoE, due to an earlier recognition of the urgent need to address PH and TBI, has been an immense help to the VCE. Efficiencies are being achieved through a robust partnership, and the DCoE collaborates with the VCE to provide strategic guidance and lessons learned. This approach has allowed the VCE leadership to be immediately active in outreach, research, and data collection and the VCE and DCoE will continue to work together and identify areas where collaboration will benefit their common mission of improving the health and quality of life for members of the Armed Forces and veterans.

FUNDING FOR THE DEFENSE CENTERS OF EXCELLENCE FOR PH AND TBI

6. Senator BEN NELSON. Ms. Embrey, over the past 2 years a great deal of money, to the tune of at least \$600 million, has been put toward PH and TBI. Do you have an assessment of how much of these funds have been directed towards the Centers of Excellence for PH and TBI?

Ms. EMBREY. As part of the supplemental funding provided, the following amounts show the Operation and Maintenance funding allocated for the DCoE for PH and TBI:

Fiscal Year 2007/2008: \$123 million
Fiscal Year 2009: \$126 million

The following amounts show the Procurement funding allocated for the DCoE for PH and TBI:

Fiscal Year 2007/2009: \$345,000

The following amounts show the Research, Development, Test, and Evaluation funding for the DCoE for PH and TBI:

Fiscal Year 2007/2008: \$45 million
Fiscal Year 2009/2010: \$90 million

7. Senator BEN NELSON. Ms. Embrey, what mechanisms are in place to vet and execute contracts to conduct research, and are there metrics in place to maintain timelines for actionable results?

Ms. EMBREY. The projects that were selected and funded were vetted by the U.S. Army Medical Research and Materiel Command's (USAMRMC) congressionally directed Medical Research Programs. In addition, USAMRMC manages the research projects, to include grant execution and project monitoring.

The process includes a review of proposals conducted according to the two-tier review model recommended by the National Academy of Sciences Institute of Medicine. This model has received high praise from the scientific community, advocacy groups, and Congress. The first tier is a scientific peer review of proposals against established criteria for determining scientific merit. The second tier is a programmatic review that compares submissions to each other and recommends proposals for funding based on scientific merit and overall program goals. Programmatic reviews of proposals are conducted by the Joint Program Integration Panel.

Fiscal Year 2009: For the obligation of future PH and TBI research funding, the DCoE for PH and TBI plans to include language developed by the U.S. Army Medical Research Acquisition Activity the fiscal year 2009 request for proposals to increase its visibility and oversight of ongoing and future research TBI and PH projects. This language is in the process of being finalized.

In support of ongoing research gap analyses and management of the DOD PH/TBI research portfolio, DCoE endorses the solicitation of periodic updates from funded research programs. The autonomous operation of independent research must be

carefully weighed against both the needs of the Department to measure intermediate progress towards an end state of a particular research product and the expectation for transparent accountability that comes with public funding.

8. Senator BEN NELSON. Ms. Embrey, do the DOD and VA maintain separate peer review processes for the evaluation of research proposals, or do they work together on proposals in the areas of PH and TBI?

Ms. EMBREY. The DOD and VA do maintain separate peer review processes for evaluating research proposals; however, the VA advises DOD research offices to develop program announcements and identify key research priorities, specifically in the areas of TBI and PH. VA and DOD personnel often serve as scientific peer reviewers on committees evaluating proposals, and the respective expertise is invaluable for determining feasibility and scientific merit. Additionally, VA staff serves as programmatic reviewers on integration panels to ensure understanding of each other's research portfolios, programmatic focus, and to help prevent funding overlap. These efforts help to reduce unnecessary redundant funding and help the agencies to leverage their existing resources.

9. Senator BEN NELSON. Ms. Embrey, to avoid duplicative efforts, who is ultimately responsible to coalesce the projects being performed by agencies and entities, such as the VA and other Federal agencies, State and private universities, and non-governmental organizations to identify gaps in research or treatment and to ensure we gain economies of scale in the efforts currently being undertaken to help improve the diagnosis and treatment of PH issues and TBI?

Ms. EMBREY. The DCoE for PH and TBI provides the nexus for research planning and monitoring across DOD and with other Federal and non-Federal agencies. In addition, the DCoE engages in activities to identify gaps in research and to avoid duplication of effort by building a PH and TBI research community. These efforts include:

- Coordinating development of recommended PH and TBI research strategies, requirements, and priorities jointly across multiple agencies;
- Working with the VA, NIH, and the Department of Education to define common data elements, definitions, metrics, outcomes, and instrumentation standards for research in PH and TBI;
- Conducting a comprehensive scan for research activities related to PH and TBI, and integrating research efforts of component centers, including the Blast Injury Research Program, VA, Federal agencies, and civilian organizations;
- Performing gap analysis using the Joint Process Integration Panel to define requirements and priorities as inputs to the overarching Health Affairs biomedical research, development testing, and evaluation (RDT&E) portfolio, joint development of requests for proposals, and both programmatic and peer reviews;
- Developing PH and TBI research and clinical practice clearinghouse capabilities;
- Consolidating and disseminating best practices and monitoring clinical investigations (non-RDT&E); and
- Translating research into practical tools, technologies, protocols, and clinical practices.

The DCoE is in the process of planning an interagency PH and TBI Research Portfolio Coordination Conference for the fall of 2009. This will help to provide the major Federal PH and TBI research funding agencies with an opportunity to develop a qualitative and quantitative understanding of each other's portfolios, and to coordinate them more strategically in the future.

The DCoE actively collaborates with the following agencies and institutions:

DOD Agencies:

- Bureau of Medicine and Surgery
- Office of Naval Research
- U.S. Army Medical Research and Materiel Command
- Armed Forces Health Surveillance Center
- Armed Forces Institute of Regenerative Medicine
- Uniformed Services University of the Health Sciences
- Center for Neuroscience and Regenerative Medicine
- Joint Improvised Explosive Device Defeat Organization
- Defense Advanced Research Projects Agency

Federal Agencies:

- VA
- NIH
- National Institute on Disability and Rehabilitation Research
- Centers for Disease Control and Prevention
- Department of Health and Human Services

Non-Federal Institutions:

- Post Traumatic Stress Disorder (PTSD)/TBI Clinical Consortium Coordinating Center
- TBI Multidisciplinary Research Consortium
- PTSD Multidisciplinary Research Consortium

VIRTUAL LIFETIME ELECTRONIC RECORD

10. Senator BEN NELSON. Admiral Timberlake, on April 9, President Obama announced plans to create a Virtual Lifetime Electronic Record, which would expand on the idea of fully interoperable electronic health record capabilities to include personnel, benefit, and administrative information. Secretary Gates and Secretary Shinseki support this plan, and I believe they chose the Interagency Program Office to take the lead on coordinating this initiative. What effect has this decision had on the Departments' plans to execute a fully interoperable electronic health record system or capability?

Admiral TIMBERLAKE. Regarding the policy guidance provided by the President and the Secretaries, the DOD/VA Interagency Program Office (IPO) is establishing a virtual lifetime electronic record working group to provide a focused requirements and management effort to accelerate the adoption and implementation of this new virtual lifetime electronic record approach. We are in the early planning stages for the virtual lifetime electronic record and will be developing the timelines as we progress, but it is important to note that this approach will leverage the Interagency Clinical Informatics Board (ICIB) in prioritizing common services for clinical care as the process moves forward. Currently the IPO is only tasked to facilitate the development of the various working groups and governance structure in determining the way ahead. Efforts related to the planning for, and implementation of, the virtual lifetime electronic record are not intended to be a replacement to our congressionally-mandated objective of achieving full interoperability for the provision of clinical care by September 2009. These two very important efforts are aligned and do not conflict with one another.

11. Senator BEN NELSON. Admiral Timberlake, will this initiative require a new system platform? If so, how do the Departments plan to fund it?

Admiral TIMBERLAKE. The foundation of the virtual lifetime electronic record effort is the implementation of a Services Oriented Architecture (SOA) approach using common services. This provides an environment in which functions can be standardized and used across systems and processes. This approach adopts industry best practices to provide an environment in which data may be accessed through links to legacy applications. The Departments are working together to identify what common services are needed, reconcile clinical and business practices where needed, and prioritize the common services to be built or acquired. As more common services are used by DOD and VA, the systems become more interoperable over time, leading to further interoperability and the effective and efficient sharing of data between the Departments.

Certain platform changes will need to be implemented to carry out the virtual lifetime electronic record mission. Such upgrades include the use of SOA to ensure that both DOD and VA systems are able to evolve, allowing for the effective and efficient integration of data sharing capabilities and services that provide the greatest benefit to our beneficiaries. Utilizing a SOA approach will provide methods for the development and integration of services by grouping functionality among common business processes. As the common services to be developed or acquired are defined, the Departments will need to estimate the resources needed.

12. Senator BEN NELSON. Admiral Timberlake, are DOD and VA still separately funding fixes and improvements to the DOD's electronic health record system, AHLTA, and the VA's health record system, VistA? How can electronic health record interoperability move forward with such a disjointed approach?

Admiral TIMBERLAKE. The DOD and VA are currently funding fixes and improvements to their respective electronic health record systems. Electronic health record

(EHR) interoperability at the present time is accomplished by ensuring the access to data using the Bidirectional Health Information Exchange (BHIE). The data are shared bi-directionally, in real time, for patients who receive care from both VA and DOD facilities and are viewable at all DOD and VA medical facilities. BHIE permits DOD providers to view BHIE data from all VA medical facilities and VA to view BHIE data from all DOD facilities. The Departments will continue to use and upgrade their current EHRs to provide and document clinical care while the way forward using a common services approach is being implemented. The evolution to the virtual lifetime electronic record will be incremental and rely on legacy systems and new common services.

EMPLOYMENT TRAINING FOR TRANSITIONING SERVICEMEMBERS

13. Senator BEN NELSON. General Meurlin and Mr. Dimsdale, many of our service men and women enter the military out of a desire to serve their country and receive the education, training, and job stability benefits the military affords. We train them to do their jobs serving our country, but if they are injured severely enough then we medically separate them. With growing economic concerns affecting job opportunities across the country, we owe it to the men and women who have served and sacrificed for our country to ensure they have the tools and skills to succeed in the civilian sector once they are separated from the military. What employment training do we provide for wounded, ill, and injured troops leaving the military?

General MEURLIN. DOD has a longstanding partnership with the Department of Labor Veterans Employment and Training Service and the VA Vocational Rehabilitation and Employment Service. DOD, DOL, and VA along with the Department of Homeland Security, formalized our partnership with a MOU. The MOU lays out each Department's areas of responsibility for the deliver of services and programs that fall under the Transition Assistance Program (TAP) and the Disabled Transition Assistance Program (DTAP). This includes programs, services, training, and new initiatives for the wounded, ill, and injured.

DOD and the Military Services Pre-separation Counseling: The process to inform and educate servicemembers (including wounded, ill, and injured about employment assistance and job training) begins with the Military Services' Pre-separation Counseling sessions. During pre-separation counseling, servicemembers are given an overview of the employment and training assistance available by DOL and VA, in addition to other resources and programs. The Military Service Transition Counselor, Army Career and Alumni Program Counselor, or the Navy Command Career Counselor schedule the servicemember to attend the next available 2½ day DOL TAP Employment Workshop, VA Benefits (4 hours) and DTAP (2 hour) Briefings as part of the pre-separation counseling process.

DOL TAP Employment Workshops: During the DOL 2½ day DOL TAP Employment Workshop, DOL's professional staff provides training and assistance on resume writing, developing cover letters, job search techniques, interview skills, and researching the job market (local, State, and national level), salary negotiation, dress for success and more. They also get information on translating their military skills into civilian language. DOL provides employment assistance, job training assistance and other DOL TAP services and programs which fall under the purview of the Secretary of Labor to all separating servicemembers, including our wounded, ill, and injured. DOL established the Recovery and Employment Assistance Lifelines (REALifelines) Program dedicated to providing individualized job training, counseling, and reemployment services to wounded, ill, and injured servicemembers. DOL has staff at 16 Military Treatment Facilities (MTFs).

VA Benefits Briefing: During the VA Benefits Briefing sessions, wounded ill and injured servicemembers are informed and educated about all VA benefits. These include information on education and training, health care, home loans, life insurance, vocational rehabilitation and employment (VR&E), disability benefits, and others. In addition, those who are wounded, ill, and injured are also scheduled to attend a separate DTAP Briefing designed solely for servicemembers leaving the military because of a service-connected disability, injury, or illness that was aggravated by military service.

Other Support and Employment Programs for Wounded, Ill, or Injured (WII): The Military Services along with other organizations provide many great support programs for wounded, ill, and injured. All of them play a pivotal role in helping our deserving servicemember with employment assistance and job training. The goal is to help WII servicemembers fulfill their aspirations and achieve their employment goals. Several programs and services are: Military OneSource; Army Wounded Warrior Program; Navy's Safe Harbor Program; Marine Corps Wounded Warrior Regi-

ment; Air Force Wounded Warrior Program; Heroes to Hometown (a DOD partnership with the American Legion for WWII servicemembers); DOL's most recent "America's Heroes at Work" project that focus on the employment challenges of returning servicemembers living with TBI and/or PTSD.

Mr. DIMSDALE. The VA Vocational Rehabilitation and Employment (VR&E) Coming Home to Work (CHTW) program provides career counseling, training and education, and employment assistance to wounded, ill, and injured servicemembers. VA has stationed full-time vocational rehabilitation counselors at major DOD MTFs. These counselors work with CHTW coordinators at VA regional offices. CHTW coordinators also provide outreach and counseling services at DOD warrior transition units, post deployment health reassessment events, and at DOD Yellow Ribbon events. The CHTW program eases servicemember transition into to civilian life by providing expedited and comprehensive training and employment services that lead to suitable employment.

14. Senator BEN NELSON. General Meurlin and Mr. Dismdale, are there incentives for companies to hire veterans?

General MEURLIN. The Department of Labor has the Work Opportunity Tax Credit (WOTC). The WOTC provides employers with Federal income tax credits for hiring certain targeted groups. Veterans and disabled veterans are groups included in the WOTC. Employers can receive up to \$4,800 in tax credits for hiring veterans. The Federal Government also has Executive Order 13360 which sets goals for Federal agencies to provide contract opportunities for Service-Disabled Veterans Owned Small Businesses. The Veterans Benefits Act (VBA) of 2003 established the set-aside programs for Service-Disabled Veteran-Owned Small Businesses (SDVOSBs). Under SDVOSB, "a contracting officer may award contracts on the basis of competition restricted to" SDVOSBs if he or she is reasonably expects that no less than two SDVOSBs will submit offers and the award can be made at a fair market price.

VA Programs that Offer Incentives:

Special Employer Incentives (SEI) - offers private companies the opportunities to hire disabled veterans who face extraordinary circumstances to obtaining suitable employment. The VA can pay the employer up to 50 percent of the veteran's salary for up to 6 months. This payment is to help the employer recoup losses in production for having a senior employee assist with training the veteran.

On-the-Job Training (OJT) - OJT is for Federal, State, local government as well as private sector employers. Employers have the opportunity to hire veterans that may need additional training on the job. The employer pays less than the journeyman wage and the VA pays the veteran a subsistence allowance to bring the salary up to the journey wage. An OJT may be a maximum of 2 years. Over time the VA pays less as the employers' portion of the veterans' salary increases. At the conclusion of the OJT, the employer is paying 100 percent of the veteran's salary at the journeyman wage.

Non-paid Work Experience (NPWE) - NPWE is for Federal, State, and local government employers. It allows a servicemember the opportunity for a smooth transition from military to civilian work by building confidence as they recover and rehab prior to being released from Active Duty. Although employment is not guaranteed, the employer is encouraged to consider hiring veterans when positions open. The employer may choose to use Federal special hiring authority to hire the veteran non-competitively: Disabled veterans enrolled in VA Training Programs or Schedule A. VR&E provides a subsistence allowance to veterans based on the number of hours worked per week.

Mr. DIMSDALE. There are several tangible incentives available for both Federal agencies and private sector firms to hire veterans. The VR&E VetSuccess program assists veterans with overcoming obstacles to employment such as lack of civilian work experience, gaps in employment, and serious employment handicaps. Federal, State, and local government employers may hire veterans through the non-paid work experience (NPWE) program or Federal on-the-job training (OJT) program. Private sector firms may hire veterans through the OJT program for nongovernment employers, or through the special employer incentive program.

The NPWE program is for Federal, State, and local government employers. This program allows a servicemember or veteran the opportunity for a smooth transition from military to civilian work by gaining meaningful work experience. The number of hours worked per week may be full or part-time depending on the participant's and employer's needs. However, during the NPWE program, VR&E provides a subsistence allowance to veterans based on the number of hours worked per week. Although employment is not guaranteed, the employer is encouraged to hire veterans when positions are open. The NPWE program provides the opportunity for veterans

to try a new job in a new setting, while allowing the employer to assess the veteran's work habits in the work setting. If the employer decides to hire the veteran, the employer may choose to use a Federal special hiring authority to hire the veteran noncompetitively: disabled veterans enrolled in VA training programs or schedule A.

The OJT program may be used by Federal, State, local government, as well as private employers. Employers have the opportunity to hire veterans that may need additional training on the job. Through the OJT program, the employer pays the veteran less than the journeyman wage and the VA pays the veteran a subsistence allowance to bring the salary to the journeyman wage. Over time the VA pays less as the employer's portion of the veteran's salary increases. At the conclusion of the OJT program, the employer is paying 100 percent of the veteran's salary at the journeyman wage. An OJT program may be a maximum of 2 years.

Another incentive program that private sector employers may use to hire veterans is the special employer incentive (SEI). This program offers private companies the opportunity to hire veterans with disabilities that face extraordinary circumstances to obtaining employment. Extraordinary circumstances may be the seriousness of the veteran's disabilities, training deficits, or significant gaps in employment. VA can pay the employer up to 50 percent of the veteran's salary for up to 6 months. This payment is to help the employer recoup losses in production for having a senior employee assist with training the veteran.

Additionally, VR&E continues to partner with the Department of Labor (DOL) Veterans' Employment Training Service (VETS) program to advance, improve, and expand employment opportunities for veterans with disabilities. The VETS program is charged to provide training and job placement services to veterans, with a special emphasis on veterans with disabilities. The VETS program provides grant programs to States, which fund local workforce boards to provide services in local communities throughout the Nation. Services are provided by disabled veteran outreach and placement (DVOP) coordinators and local veterans employment representatives (LVER) at local "one-stop" workforce board organizations. The DVOPs and LVERs are also co-located at VR&E offices throughout the country. DVOPs and LVERs work with veterans in VR&E from initial orientation through successful job placement by providing labor market information, job readiness services (interviewing skills and resume preparation), and job placement assistance for veterans enrolled in the VR&E program.

15. Senator BEN NELSON. General Meurlin and Mr. Dimsdale, we know there is a shortage of behavioral health care professionals nationwide. Would it make sense for the DOD to adopt a program where they retain, educate, and train behavioral health care professionals for the force? As in other education programs, the servicemembers would need to apply and be selected. Could this concept potentially work for those who are being medically separated?

General MEURLIN. All Service components provide career opportunities based upon level of injuries and aptitude. The Services have been tasked to give directives and assignment limitations for wounded warriors with an expected completion date of June.

Additionally, the Department has, over the past 2 years, been expanding educational programs for non-physician behavioral health specialties and continues to look at other opportunities to improve front-line mental health care. We have been working with the University of Southern California, which has developed a new Military Masters in Social Work program, as a potential source of new clinical social workers. We are also considering the development of a scholarship program for training civilians in behavioral health fields. Advanced degree programs are also being created. The Uniformed Services University of the Health Sciences currently has a PhD in Clinical Psychology program for military students and a similar PhD in Medical Psychology program with a clinical track for research-oriented clinical psychologists in the academic tradition. The Army has a Masters program with Fayetteville State University, NC (taught in San Antonio, TX) that provides social workers in uniform with a special counseling skill on deployment issues.

Mr. DIMSDALE. This question is specific to DOD and cannot be addressed by VA.

HIRING AUTHORITY FOR CIVILIAN HEALTH CARE EMPLOYEES

16. Senator BEN NELSON. Ms. McGinn, the Wounded Warrior Act authorized enhanced appointment and compensation authority for civilian health care personnel by authorizing DOD to exercise any authority under chapter 74 of title 38, which covers pay and hiring authorities of the VA. This would enhance DOD's pay and

hiring authorities for purposes of recruitment, employment, and retention of civilian health care professionals. Has DOD used these authorities? If not, does it plan to?

Ms. MCGINN. The Department uses recruitment and compensation authorities for health care practitioners under both the Office of Personnel Management (OPM) title 38 delegation agreement and the provisions of the Wounded Warrior Act.

OPM delegated to the Department a number of the VA title 38 authorities via an agreement that was originally issued in 1994, and which was subsequently updated in July 2002 and July 2006. Incident to this delegation agreement, the Department has instituted a number of compensation flexibilities, as described below, to facilitate recruitment and retention of health care practitioners. These authorities are working well and do not need any modifications to improve their effectiveness.

- Special Salary Rate Authority: This authority is currently being used by DOD to set special salary rates. It is used mainly for nurses and pharmacists.
- Baylor Plan: This authority was authorized for use in DOD in 1996, but has had limited application.
- Premium Pay: The authority to pay Call Back Premium Pay was authorized in 1996.
- Head Nurse Pay and Nurse Executive Special Pay: Head nurse pay was authorized in August 2005, and is currently in use in the Department.
- Hours of Employment: There is no evidence that this authority is being used. This authority may not be necessary given the higher salary levels provided under the National Security Personnel System (NSPS).

Under the Wounded Warrior Act, the Department is pursuing two major initiatives: an expedited hiring authority for healthcare practitioners and a new compensation system for non-NSPS physicians and dentists. We expect the expedited hiring authority to be released to the components by July 1, 2009. The delay in its delegation stemmed from an assessment of a recent court case on adjudication of certain veterans preference cases and the impact that ruling would have on the procedures for this authority. We have received the necessary guidance and have written the procedures for using the authority. We also need information on what type of positions should be covered by this expedited hiring authority. That information has been requested and we expect to have it collected by mid-June.

The Policy Instruction for the new physicians/dentists compensation pay system was issued in December 2008. We are currently finalizing the system procedures and applicable salary survey instruments, with a scheduled conversion date for late September 2009. This system will be applicable to non-NSPS physicians and dentists and will enable the DOD to pay these employees a salary comparable to that paid by VA and under NSPS.

In addition to the title 38 authorities, DOD has been making very effective use of the title 5 recruitment, relocation, and retention incentives. In 2008, DOD spent approximately \$46 million on these incentives for employees in the medical occupations. Over 4,500 incentives were processed, with an average value of over \$10,000.

DOD continues to make effective use of the Physicians Comparability Allowance, and plans to do so until the allowance amount is included into the physicians' pay under the Physicians and Dentists Pay Plan or NSPS.

17. Senator BEN NELSON. Ms. McGinn, does DOD need any additional legislation to implement these hiring authorities?

Ms. MCGINN. Not at the present time. The Wounded Warrior Act has authorized enhanced appointment and compensation authority for civilian health care personnel by authorizing the DOD to exercise any authority under chapter 74 of title 38. This enhances DOD's pay and hiring authorities for purposes of recruitment, employment, and retention of civilian health care professionals.

WOUNDED WARRIOR INFORMATION RESOURCES

18. Senator BEN NELSON. General Meurlin and Mr. Dimsdale, you both mentioned the National Resource Directory (NRD) in your written statements as a jointly developed source of national, State, and local information for servicemembers, veterans, and their families. How is the National Resource Center different from the Wounded Warrior Resource Center that was mandated by the Wounded Warrior Act as a single point of contact for wounded, ill, and injured servicemembers, veterans, families, and caregivers?

General MEURLIN. The NRD, www.nationalresourcedirectory.org, is an online tool for servicemembers, veterans, their families, and those who support them. It provides access to more than 11,000 services and resources from Federal, State, local

government programs and agencies, as well as philanthropic, academic institutions and professional associations, nonprofit and community-based organizations, Veteran Service, and nongovernmental organizations. The NRD offers information on: Benefits and Compensation, Education, Employment and Training, Family and Caregiver Support, Health, Housing and Transportation, Services and Resources, and Key Contact Information.

The NRD, maintained through a collaborative partnership among DOD Labor and VA, was created to answer the needs identified by wounded, ill, and injured servicemembers, veterans, and families to provide a comprehensive online tool available to assist in transitioning into the civilian community. It is also part of a larger effort to improve wounded warrior care coordination and access to information on services and resources, key goals identified by both the President's Commission on Care for America's Returning Wounded Warriors (Dole-Shalala Commission) and Title XVI, "Wounded Warrior Matters," of the 2008 National Defense Authorization Act (NDAA). The NRD will also assist with the MyeBenefits effort.

In April 2009, there were more than 60,000 hits to pages within the NRD. The TAP received the most hits to a single page; over 20,000 users accessed some form of information contained with the VA's website.

The Wounded Warrior Resource Center (WWRC) Web site, www.woundedwarriorresourcecenter.com, meets the requirements of NDAA for Fiscal Year 2008, section 1616, which states: "(b) Access. The center shall provide multiple methods of access, including at a minimum an Internet website and a toll-free telephone number (commonly referred to as a hot line) at which personnel are accessible at all times to receive reports of deficiencies or provide information about covered military facilities, health care services, or military benefits."

In response to this mandate, The WWRC Web site, a DOD site, provides wounded servicemembers, their families, and caregivers with information they need on military facilities, health care services, and benefits. It provides access to 1,000 links and supports access to the WWRC Call Center (also mandated by the NDAA), run by Military OneSource (MOS) with trained specialists who are available 24 hours a day, 7 days a week by phone at 1-800-342-9647 or by e-mail at wwrc@militaryonesource.com.

The WWRC Web site also provides access to FAQs, handbooks, and checklists for servicemembers, their families, and caregivers.

In April 2009, the WWRC had 1,362 hits.

Mr. DIMSDALE. The NRD is an online tool for servicemembers, veterans, their families, and those who support them. It provides access to more than 11,000 services and resources from Federal, State, local government programs and agencies as well as philanthropic, academic institutions and professional associations, nonprofit and community-based organizations, veteran service, and nongovernmental organizations. The NRD offers information on: benefits and compensation, education, employment and training, family and caregiver support, health, housing and transportation, services and resources, and key contact information.

The NRD, maintained through a collaborative partnership among the DOD, DOL, and VA, was created to answer the needs identified by wounded, ill, and injured servicemembers, veterans, and families to provide a comprehensive online tool available to assist in transitioning into the civilian community. It is also part of a larger effort to improve wounded warrior care coordination and access to information on services and resources, key goals identified by both the President's Commission on Care for America's Returning Wounded Warriors (Dole-Shalala Commission) and Title XVI, Wounded Warrior Matters, of the 2008 NDAA.

In April 2009, there were more than 60,000 hits to pages within the NRD. The TAP received the most hits to a single page; over 20,000 users accessed some form of information contained with the VA's Web site.

The WWRC Web site meets the requirements of NDAA Section 1616 which states: "(b) Access. The center shall provide multiple methods of access, including at a minimum an Internet website and a toll-free telephone number (commonly referred to as a hot line) at which personnel are accessible at all times to receive reports of deficiencies or provide information about covered military facilities, health care services, or military benefits." In response to this mandate, the WWRC Web site, a DOD site, provides wounded servicemembers, their families, and caregivers with information they need on military facilities, health care services, and benefits. It provides access to 1,000 links and supports access to the wounded warrior resource call center (also mandated by the NDAA), run by Military OneSource (MOS) with trained specialists who are available 24 hours a day, 7 days a week by phone at 1-800-342-9647 or by e-mail at wwrc@militaryonesource.com. The WWRC Web site also provides access to frequently asked questions, handbooks, and checklists for

servicemembers, their families, and caregivers. In April 2009, the WWRC had 1,362 hits.

19. Senator BEN NELSON. General Meurlin and Mr. Dimsdale, does having two major similar resources duplicate efforts or risk causing confusion for wounded servicemembers and veterans and their families?

General MEURLIN. We believe that the WWRC Web site is duplicative of the information contained within the NRD. All of the links found on the WWRC Web site are also on the NRD. However the NRD, which is a tri-agency effort between DOD, Labor, and VA, reaches a wider audience and offers more services and resources than the WWRC Web site.

Mr. DIMSDALE. VA believes that the WWRC Web site is duplicative of the information contained within the NRD. All of the links found on the WWRC Web site are also on the NRD. Additionally, the majority of the questions received on the WWRC Web site are similar if not the same as questions received on the MOS Web site, or received by the wounded warrior resource call center run by MOS. The NRD, as a tri-agency effort, reaches a wider audience and offers more services and resources than the WWRC Web site.

CLEAN SHEET REVIEW

20. Senator BEN NELSON. Ms. McGinn and Mr. Dimsdale, the Senior Oversight Committee (SOC) initially established eight lines of action to address issues regarding warriors in transition. One of these lines of action, which is now completed, was called a Clean Sheet Design, to answer the question of what we would do, having reviewed all of the issues, if we could start over with a clean sheet of paper? Did this line of action recommend a system that would be different from what we have today? If so, what would it look like?

Ms. MCGINN. Yes. The Clean Sheet Design did recommend a system that would be different from what we have today.

The major features of the Clean Sheet Design are:

1. Ability Assessment. For both the decisions that determine whether or not a person is fit to continue in military service and that determine the level of compensation for those who are leaving the military, these recommendations would provide for an ability assessment rather than a disability evaluation. This is perceived to encourage a focus on rehabilitation, education, and training to reach full potential rather than a focus on limitations. The assessment would include a psychological/physical medical evaluation, a mental acuity assessment, and an aptitude assessment.

2. Continuation of Military Service (COMS). These recommendations would streamline and accelerate the process by which servicemembers are identified as candidates for the continuation of military service decision and help them move more quickly to begin their assimilation into a new life (if appropriate), while ensuring that there is no penalty (in terms of benefits or compensation) from leaving the service and providing return rights if full recovery is more extensive than expected.

3. Compensation. These recommendations provide for three components of compensation: military service annuity (based on years of service and base pay); income replacement (may be permanent, but focused on providing income while recovering and participating in vocational rehabilitation to transition to a new career); and WII compensation that would recognize the significant quality of life impact. (This could be adjusted up or down throughout the servicemembers or veteran's life, depending upon significant changes in conditions.)

4. Care. These recommendations would establish open access to all DOD and VA facilities for all wounded, injured, or ill servicemembers or veterans to ensure that access to care is not dependent on military status. (Enable joint facilities in selected areas and promote the idea of 'Federal health care facilities' to ensure that servicemembers and veterans understand that they are appreciated by their country and their government, not just their military service.)

5. Consolidated Access to Benefits. To ensure that servicemembers and veterans do not have to navigate the myriad of benefits (and associated paperwork) that may be available to them, these recommendations would create an expedited, centralized capability to support the process by which benefits are identified, obtained, adjusted, and updated and ensure that

servicemembers, veterans, and their families have the correct benefits available at the correct time.

6. Information Access. These recommendations would promote and develop capabilities for the seamless exchange of information across organizations to provide consistent, timely support and care. The recommendations would enable access to all relevant records to those who need it to track, update, and retrieve information about health care and personnel status, provide health care practitioners with additional insight into the incident that caused a wound, injury, or illness. (The recent project to develop a Virtual Lifetime Electronic Record announced by the President and the Secretaries of DOD and VA would achieve these goals.)

7. Continuous Improvement and Oversight. These recommendations would establish an oversight body and define metrics to monitor success. They would also clarify roles, accountability and reporting procedures.

Mr. DIMSDALE. The Clean Sheet Review sets aside all existing constraints; e.g., Public Law, departmental policy, existing organizational boundaries, human capital strategies, and budgets, to portray a holistic, end-to-end support structure. The design addresses the needs of wounded, injured, and ill servicemembers/veterans and, from their perspective, provides overlapping, coordinated care from the point-of-wound/injury or onset of illness through their reintegration into military or civilian community and beyond. The Clean Sheet Review recommended:

(1) A continuation of military service decision by three processes based on severity of injury, similar to the three categories implemented by the Federal recovery coordinator/recovery care coordinator architecture;

(2) A conversion from a disability assessment to an ability assessment that drives the clinical care regimen, identification of needed benefits, the ability of a servicemember to continue their military career, and compensation;

(3) Compensation including a military service annuity based on time in service and base pay, paid for life, income replacement and quality of life compensation;

(4) Access to military/VA or civilian medical treatment facilities (MTFs) that best meet a servicemember or veteran's relevant clinical needs and are most convenient to where they work or live without regard to their status as servicemembers or veterans and at no additional cost;

(5) Consolidation of benefits delivery from a single care management team that functions as single approval authority for all Federal benefits;

(6) A convergence of information that supports managed access to all relevant systems through a centralized portal for all approved stakeholders and agents of the process; and

7) A continuous process improvement and oversight function to ensure responsiveness to wounded warriors and their families, and constant process improvement to changing conditions and opportunities.

ELECTRONIC HEALTH RECORDS OF PRIVATE SECTOR CARE

21. Senator BEN NELSON. Admiral Timberlake, the Interagency Program Office has focused a great deal on getting DOD and VA medical records online and interoperable. However, it is estimated that up to 60 percent of medical care given to all servicemembers and their eligible dependents is provided by private health care professionals, outside of military or veterans medical facilities. Is the Interagency Program Office taking steps to include records of medical care provided outside of MTFs or VA medical centers, in order to create a truly comprehensive electronic health record?

Admiral TIMBERLAKE. The virtual lifetime electronic record will foster interoperability and interchangeability through the use of common services, and support both the health mission of providers and the health needs of our warfighters. The open standards/open architecture technologies employed in the structure will facilitate secure, appropriate, and cost-effective data sharing with DOD, VA, and DOD managed care support contractors.

The Departments' approach to the virtual lifetime electronic record will adopt industry best practices to provide an environment with links to new and legacy applications through service-oriented architecture using common services. Creating a truly comprehensive EHR will be accomplished by referencing national standards for health-related data guided by the Department of Health and Human Services (HHS). The virtual lifetime electronic record effort will help facilitate the effort to-

wards achieving President Obama's goal of allowing for data sharing with the private sector.

Additionally, as the Nationwide Health Information Network (NHIN) is developed and matures, it will be the means to obtain information from civilian healthcare providers and for them to gain appropriate access to the virtual lifetime electronic record. Recognizing that many private sector care clinical providers are not currently using electronic health records, DOD is developing the ability to scan paper records, make them available through AHLTA, and share them with VA. For example, if a patient is referred to a private sector provider and returns to the MTF with a consult report, that report can be scanned with the appropriate identifying information so others will know what it is and be able to access it.

ACCESS TO ADDITIONAL BEHAVIORAL HEALTH CARE PROVIDERS

22. Senator BEN NELSON. Ms. Embrey, you state in your written testimony that the Department "funded the hiring of additional mental health and other specialty providers by the Services, and implemented a policy that requires first appointment access within 7 days for mental health concerns." How many additional positions were funded, and is it enough?

Ms. EMBREY. In the past 2 years, Office of the Assistant Secretary of Defense (Health Affairs) has funded an additional 1,700 positions for mental health providers, to include contractors, to work in MTFs. We are also partnering with the Public Health Service to increase our number of mental health providers. Around each MTF, we have established a network of private care providers to augment the MTF's capability and capacity. When an MTF cannot satisfy the demand for mental health services, it uses the established referral process to obtain timely care for TRICARE beneficiaries from private care sources. To ensure availability of providers for this referred care, TRICARE has added more than 10,000 mental health professionals to the network during the past 2 years. As a result of the combination of MTF and network mental health capability and capacity, TRICARE beneficiaries do not currently encounter any systemic problems in obtaining timely access to mental health care.

23. Senator BEN NELSON. Ms. Embrey, if additional behavioral health care positions were authorized, would the Services be able to recruit and hire them, given the national shortage of these providers?

Ms. EMBREY. Yes, the Services would be able to recruit and hire additional behavioral healthcare providers. National needs for mental health providers are developed by agencies such as the National Institutes of Mental Health, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration—they have responsibilities related to mental health services throughout America. The DOD and VA are working closely on all aspects of identifying and meeting mental health staffing requirements for our wounded warriors and veterans; we have established a working partnership. DOD's mental health provider requirements are based on the needs of our wounded warriors, their families, and our beneficiaries. We are constantly adjusting these requirements.

Medical workforce planning efforts throughout the DOD have streamlined the hiring process of behavioral healthcare providers, utilizing the appointing flexibilities we have as well as compensation incentives. We are now much more competitive for scarce and shortage healthcare providers. As a result, DOD has been able to increase recruitment and hiring of many behavioral healthcare positions.

24. Senator BEN NELSON. Ms. Embrey, does the Department's policy of access to mental health care within 7 days apply only to wounded, ill, and injured servicemembers? Does it apply to family member beneficiaries?

Ms. EMBREY. Access standards apply to all TRICARE Prime enrollees, including Active Duty servicemembers and their eligible family members, retirees and their eligible family members, survivors, and certain other beneficiaries who might be enrolled in Prime.

25. Senator BEN NELSON. Ms. Embrey, are the Services meeting the Department's policy of access to mental health care within 7 days?

Ms. EMBREY. MTFs are meeting this access standard, although not all MTFs have mental health (MH) specialty services (small units) and some do not provide MH specialty services to civilian beneficiaries. Ninety-six percent of those seen in military mental health clinics are seen initially as "walk-ins" at the time of their initial contact with the clinic. Approximately 80 percent of those seen by appointment are

seen within 7 days. Across the enterprise, more than 99.5 percent of those seen initially (who have had a minimum of 6 months without previous contact) for MH specialty care in military clinics are seen within the access standard.

TRICARE provides Behavioral Health Provider Locators to assist beneficiaries to receive routine initial access (7 days or less) to network MH specialty providers. Most beneficiaries report by survey little to no problems accessing MH providers. Coverage includes up to eight sessions without a referral or authorization. Families of both Active Duty and activated Reserve component personnel receive full health care coverage, including MH benefits. Coverage for Reserve members continues up to 6 months after deactivation and will continue beyond that if they enroll in TRICARE Reserve Select.

QUESTIONS SUBMITTED BY SENATOR LINDSEY GRAHAM

CONGRESSIONAL EFFORTS

26. Senator GRAHAM. Mr. Williamson, Mr. Bertoni, and Ms. Melvin, you have heard the concerns of our first panel of witnesses, and analyzed the government's response. Where are the gaps in policy and law that Congress needs to fill?

Mr. WILLIAMSON, Mr. BERTONI, and Ms. MELVIN. During our review of the status of DOD and VA's efforts to jointly develop the policies required by the NDAA of 2008),⁸ agency officials described two instances in which gaps in policy and law may need to be addressed. In one case, an official from the Wounded, Ill, and Injured SOC told us that one of the SOC's work groups had been contributing to legislation for improving support to caregivers of recovering servicemembers. In January 2009, the SOC approved the workgroup's proposal. A provision for caregiver benefits based on the SOC's proposal was included in the NDAA 2010 bill that was introduced in May 2009.⁹ In a second case, SOC officials told us that legislation may be needed to reconcile some of the eight outstanding wounded warrior-related definitions between the departments.

Further, our review of the military's temporary disability retired list (TDRL) identified two gaps in policy or law. First, in April 2009, we reported that DOD's temporary retirement program did not appear to be fulfilling one of its original objectives, that is, to return temporary retirees to military duty.¹⁰ Currently, only about 1 percent of temporary retirees return to the military, suggesting that the purpose of temporary disability retirement in today's military may need to be clarified. Moreover, on average, it took far fewer than 60 months to arrive at permanent disability rating decisions in most cases we reviewed. As such, the 5-year maximum eligibility period for these benefits maybe too long, particularly in view of wounded servicemembers' need for efficient resolution of their disability cases. Second, according to TDRL administrative staff, delays in reexaminations for temporary retirees are common because of limited MTF resources. Yet, staff indicated that the military rarely exercises its option to use medical reexaminations performed by civilian and VA physicians. A clearer policy regarding use of nonmilitary medical resources in these cases could reduce the MTFs' workload and the burden re-examinations place on temporary retirees.

With respect to DOD's and VA's pilot of a joint system for evaluating disabilities, we did not set out to and therefore did not identify gaps in policy or law. However, one of the pilot's objectives is to identify potential legal and policy revisions that could enhance disability evaluation efficiency and effectiveness. As pilot expansion continues, and additional experience is gained from implementing the pilot at different locations, DOD or VA may decide to submit legislative proposals to Congress to change law or policy related to disability evaluation.

27. Senator GRAHAM. Mr. Williamson, Mr. Bertoni, and Ms. Melvin, policies are only as good as the institutions and people whose job it is to carry them out. Do we have the most effective mechanisms in place today to monitor how effectively policies are executed?

Mr. WILLIAMSON, Mr. BERTONI, and Ms. MELVIN. DOD and VA could benefit from effective mechanisms to monitor and oversee policy and program execution. In prior work, we have identified various examples of limitations or shortcomings in the departments' efforts for monitoring to ensure that policies are effectively executed.

⁸Pub. L. No. 110-181, 122 Stat. 3.

⁹S. 1033, 111th Cong. § 701 (2009).

¹⁰GAO, Military Disability Retirement: Closer Monitoring Would Improve the Temporary Retirement Process, GAO-09-289 (Washington, DC: Apr. 13, 2009).

- In September 2008, we reported on the joint DOD–VA disability evaluation pilot, noting that the departments needed to maintain leadership oversight of the pilot to ensure that needed resources are identified, implementation challenges are overcome, and intended results are achieved—facilitating successful implementation of potential widespread changes to the disability evaluation process.¹¹ Subsequently, DOD created a new organizational structure—the Office of Transition Policy and Care Coordination—to oversee transition support for all servicemembers, including the pilot initiative. However, in recent testimony, we reported that while some staff believed this change would provide focus to implementing key policy initiatives, including the pilot, other staff were concerned the change may have a negative impact on the unity of command within the SOC.
- Beyond the oversight structure, the DOD and VA plan to leverage other mechanisms to help execute the pilot process; however, the effectiveness of these mechanisms may diminish over time. DOD and VA are using local agreement to establish the pilot in new locations, based on the Benefits Delivery at Discharge (BDD) model. These agreements reflect local collaboration on pilot implementation, notably to ensure that participants receive timely examinations. Nonetheless, while local agreements may be an effective tool for implementing change involving many parties, we have found in our review of the BDD program that their effectiveness may fade over time. In September 2008, we reported that the departments have relied on local MOU at 130 military bases to execute the BDD program—a program intended to expedite the application process for and receipt of VA disability benefits to eligible servicemembers.¹² However, some bases faced difficulties executing the program as agreed to in local MOUs due to changes in base command and lack of communication between the agencies or resource constraints, which negatively affected the efficiency of and access to the BDD program. As such, we recommended that VA and DOD take additional steps to ensure best practices related to the BDD program are disseminated across locations.¹³ Both agencies agreed with this recommendation.
- In addition, our work examining military temporary disability retirement, found that currently, there are not effective mechanisms in place to monitor and ensure appropriate placement on the TDRL or efficient processing of TDRL cases.¹⁴ DOD does not use available data on outcomes in past TDRL cases to avoid unnecessarily placing servicemembers on temporary retirement whose disabilities are unlikely to change in severity. Moreover, current quality assurance procedures do not provide for the systematic monitoring of TDRL placement decision accuracy and consistency. In addition, DOD does not have an effective system for monitoring the timeliness of re-examinations or a clear policy for addressing noncompliance with TDRL requirements—mechanisms that would help prevent lengthy delays in final disability determinations in TDRL cases.
- Further, our recent study of VA training for disability compensation claims processors found that the Department does not centrally evaluate or collect feedback on training provided to disability claims processors agency-wide.¹⁵ As a result, it lacks information on the adequacy of this training—information critical to its efforts to overcome claims backlogs. The Department concurred with our recommendation that it collect and review feedback from claims processors on their training conducted at VA regional offices to determine if the 80-hour annual training requirement is appropriate and the extent to which this training is relevant given their duties and experience.

Beyond these examples, our current work has focused on DOD’s and VA’s joint development of the comprehensive policies to improve the care, management, and transition of recovering servicemembers, as required by the NDAA 2008. While the previous examples address related topics, our assessments of the status of imple-

¹¹ GAO, Military Disability System: Increased Supports for Servicemember and Better Pilot Planning Could Improve the Disability Evaluation Process, GAO–08–1137 (Washington, DC: Sept. 24, 2008).

¹² GAO, Veterans’ Disability Benefits: Better Accountability and Access Would Improve the Benefits Delivery at Discharge Program, GAO–08–901, (Washington, DC, Sept. 9, 2008).

¹³ This recommendation was given to VA and DOD under the auspice of the Chairs of the Joint Executive Council.

¹⁴ GAO–09–289.

¹⁵ GAO, Veterans’ Benefits: Increased Focus on Evaluation and Accountability Would Enhance Training and Performance Management for Claims Processors, GAO–08–561, (Washington, DC: May 27, 2008).

mentation and the effectiveness of specific policies required by the NDAA 2008 will be addressed in future reports. For example, as part of our follow-on work, we plan to examine VA's and DOD's implementation of the Federal Recovery Coordination and Recovery Care Coordination Programs, which would include an assessment of how the departments are monitoring the care provided to recovering servicemembers.

28. Senator GRAHAM. Mr. Williamson, Mr. Bertoni, and Ms. Melvin, how will we know if laws and policies have made a positive difference for wounded servicemembers and their families, or not?

Mr. WILLIAMSON, Mr. BERTONI, and Ms. MELVIN. Performance goals and measures, and other evaluation tools, are key instruments for determining whether a positive impact has resulted from a given law, policy, or program. In this regard, NDAA 2008 directed DOD and VA to enhance their efforts to obtain meaningful feedback from patients and their families in order to accurately assess the quality of services provided to recovering servicemembers and facilitate the oversight of care and services. Additionally, once the departments have implemented the policies outlined in the NDAA 2008, we and others will be better positioned to evaluate whether the policy improvements are making a positive difference for wounded servicemembers.

Nonetheless, our prior work on topics examining the policies outlined in the NDAA 2008 have identified various instances where the departments could improve their performance measures and efforts to evaluate disability evaluations and related programs.

- In September 2008, we reported that while DOD and VA had established measures for the Disability Evaluation System (DES) pilot's performance, and a mechanism for tracking performance, they had not established criteria for determining whether the pilot was successful and should be expanded on a large scale. For example, they did not establish how much improvement in timeliness or other indicators would be needed before deciding that the pilot was successful. The agencies plan to issue their final report to Congress in August 2009; however, it is unclear whether they will have identified success criteria or collected sufficient performance data on key indicators in order to determine that the pilot was a success and a candidate for large-scale implementation.
- Our September 2008 report also noted that the Army faced challenges in demonstrating that improvements made to its disability evaluations process have had an overall positive impact on servicemembers' satisfaction, because it had not implemented a survey that adequately targets and queries servicemembers who are undergoing disability evaluations. We recommended that the Army administer existing surveys to a representative sample of servicemembers undergoing the disability evaluation process, and consider developing additional questions to better assess outreach and support provided by Army legal staff throughout the process. DOD agreed.
- With respect to the Benefits Delivery at Discharge (BDD) program, we reported that DOD lacked sufficient measures to track outreach to servicemembers about the program.¹⁶ While VA and DOD had coordinated to raise servicemembers' awareness about the program through VA benefits briefings, DOD was using a flawed measure for determining the extent to which VA benefits briefings were reaching all transitioning servicemembers who could benefit from the program. We recommended that DOD take steps to ensure more accurate measurement of servicemember participation in transition briefings and establish a specific plan to meet its goal of 85 percent participation. DOD agreed with this recommendation.
- Also on the BDD review, we found that VA and DOD lacked the ability to measure the extent to which members of the National Guard and Reserves have comparable access to programs that expedite their VA disability benefits relative to other servicemembers. Due to their rapid demobilization, National Guard and Reserve members often cannot access the BDD program. In response, VA established an alternative pre-discharge program, which allows National Guard and Reserve members to begin aspects of the application process early to expedite receipt of their benefits. However, VA does not collect sufficient data to determine the extent to which National Guard and Reserve members are participating in and receiving expedited benefits under either program. We recommended that VA

¹⁶GAO-08-901.

collect data for all claims filed by component and analyze the extent to which different components are filing claims and receiving timely benefits under BDD, predischARGE, and traditional claims processes. VA agreed with this recommendation.

- Beyond DOD and VA disability programs, we also found opportunities for improvement related to program measures used in VA's Vocational Rehabilitation and Employment (VR&E) program. In our January 2009 report, we noted that VA was not adequately reporting program outcomes, which could limit understanding of the program's performance. Accordingly, we recommended that VA separately report both the annual percentage of those who obtain employment and the percentage of those who achieve independent living to increase the transparency of VR&E's program performance.¹⁷ VA agreed with our recommendation and indicated it will implement new performance measures in fiscal year 2010.

ELECTRONIC HEALTH RECORDS

29. Senator GRAHAM. Mr. Williamson, Mr. Bertoni, and Ms. Melvin, DOD and VA have been working on interoperable health care records for nearly a decade. Congress imposed a deadline of September 2009 for a fully functional, interoperable health care record for military retirees and veterans. Are they going to make it?

Mr. WILLIAMSON, Mr. BERTONI, and Ms. MELVIN. It is unclear whether DOD and VA will meet the September 2009 deadline for a fully functional, interoperable health care record. As previously mentioned in our response to question 3, the departments have not developed results-oriented goals that can be used to measure and report progress toward delivering new capabilities. As such, there is no basis to effectively assess the extent to which the departments will achieve fully interoperable capabilities by September 2009.

30. Senator GRAHAM. Admiral Timberlake, you have until September 2009 to develop and implement a fully interoperable health care capability for DOD and VA. Are you going to make it?

Admiral TIMBERLAKE. The IPO does not currently anticipate any major impediments to achieving full interoperability for the provision of clinical care by September 30, 2009. The DOD/VA IPO will provide management and oversight of potential risks involving the identification, coordination, and approval of information sharing requirements and the impact these processes may have on DOD/VA information sharing milestones.

The Interagency Clinical Informatics Board (ICIB) is a clinician-led group whose proponents are the DOD Deputy Assistant Secretary for Clinical and Program Policy and the VA Chief Patient Care Services Officer, Veterans Health Administration. The ICIB is co-chaired by designees of the proponents and includes representation from DOD and VA clinicians, information technology community, interagency sharing offices, Veterans Benefits Administration, DOD and VA local Joint Venture sites, Chief Medical Informatics Officers, and others.

The DOD/VA Interagency Clinical Informatics Board defined the "fully interoperable" requirements needed by healthcare providers for the provision of clinical care. Efforts are underway to deliver full interoperability for the provision of clinical care by September 2009.

31. Senator GRAHAM. Admiral Timberlake, what do you say to skeptics who believe that you are just playing with semantics when you assert that the goal will be achieved—skeptics who also question the ability of DOD and VA to deliver joint electronic capabilities, whether it be in the battlefield, or back home, where and when they are needed?

Admiral TIMBERLAKE. While great successes have been achieved to date, as we go forward to enhance the interoperability with the vision for the virtual lifetime electronic record agreed to by the Secretaries on March 24th, the key interoperability challenges will include:

- Developing, adopting, and maturing standards at the national level to ensure efficient operational use
- Updating systems, infrastructure, and technology consistent with emerging standards

¹⁷ GAO, VA Vocational Rehabilitation and Employment: Better Incentives, Workforce Planning, and Performance Reporting Could Improve Program, GAO-09-34 (Washington, DC: Jan. 26, 2009).

- Identifying and prioritizing information requirements as defined by the business process owners and the functional community
- Identifying, prioritizing, and implementing common services

The departments also face challenges created by: different acquisition and funding cycles; different contracting processes; and differences in IA certification processes for VA, DOD, DISA, the Services, and the local level.

We are working to not only identify areas where potential process differences may exist, but the departments and the IPO are collaboratively engaging in efforts to ensure that any impediment that may arise is resolved in an efficient manner.

WOUNDED WARRIOR ACT'S FINAL VISION

32. Senator GRAHAM. Mr. Williamson, Mr. Bertoni, and Ms. Melvin, what are the biggest pieces of unfinished business that we as a Nation need to address in order to achieve the vision of the Wounded Warrior Act?

Mr. WILLIAMSON, Mr. BERTONI, and Ms. MELVIN. Among the most significant matters that need to be addressed to achieve the vision of the Wounded Warrior Act are improving customer-centered care within DOD and VA, ensuring the continuation of high-level leadership and attention to wounded warrior matters, improving the management of disability programs, and sharing electronic health records. For example, DOD and VA officials told us that the most difficult challenge in their efforts to improve the care, management, and transition of recovering servicemembers is to introduce needed cultural changes within their organizations—for example, to center medical care on the patient and to make the welfare of recovering servicemembers a higher priority. These cultural shifts represent a change to the tradition that the needs of military predominate over those of individuals, especially individuals who may not be able to return to a combat role.

It is important that DOD's and VA's leaders maintain their focus on wounded warrior issues so that the processes, services, and benefits for recovering servicemembers continue to improve. The SOC has provided high-level leadership and focused attention on the development of solutions to many of the obstacles confronting recovering servicemembers. Sustained attention by DOD and VA top leadership is needed to ensure that as circumstances change and new issues emerge, actions are taken to address the challenges that remain for recovering servicemembers and their families.

Further, managing disability evaluation and employment workloads with finite resources while maintaining accuracy, consistency, and timeliness of decisions will likely require continued focus on the part of DOD and VA. For example, in September 2008, we reported that the Army was experiencing delays in processing disability evaluations due to a shortage of key personnel and caseload surges, and identified specific gaps in legal supports, outreach and other supports to help servicemembers navigate the disability evaluation process. We made several recommendations to improve the efficiency of the process and supports to servicemembers. DOD generally agreed with our recommendations. Also, in February 2008, we reported that VA continues to face challenges in reducing the number of claims pending, speeding up the process of deciding claims, and improving accuracy and consistency of decisions across regional offices.¹⁸ Despite steps pursued by VA to improve the process, we reported that more fundamental reform may be needed. We are currently reviewing VA's disability claims workload and progress toward addressing these challenges. Further, in our VR&E report, we noted that the program had not gathered data on the number of staff it needs and was not using relevant data to identify future staffing needs.¹⁹ We recommended that VR&E engage in a strategic workforce planning process. VA agreed with our recommendation and indicated that VR&E would complete a study by the end of fiscal year 2010 to help it determine an appropriate counselor caseload.

DOD and VA also need to complete the DES pilot, and determine whether the pilot process will become the way disability evaluations are conducted by both agencies. Once that decision is made, sustained management focus will be critical to ensuring successful implementation of any joint DOD/VA disability evaluation process on a large scale. Implementation of a joint disability evaluation process would address one of the issues that we have highlighted in our Improving and Modernizing

¹⁸ GAO, Veterans' Disability Benefits: Claims Processing Challenges Persist, while VA Continues to Take Steps to Address Them, GAO-08-473T (Washington, DC: Feb. 14, 2008).

¹⁹ GAO-09-34.

Federal Disability Programs High-Risk Area—in efficient processing of disability evaluations.²⁰

Our work to date has also identified a number of persistent challenges particular to the National Guard and Reserves community. For example, in our September 2008 report, we reported that the Army faces particular challenges in meeting timeliness goals for completing disability evaluations for reservists—who comprised about 20 percent of those undergoing disability evaluations in 2007. We recommended that the Army explore approaches to improving reservists' case development. DOD agreed with this recommendation. Also, as noted previously, we recommended that VA needs to take steps to better determine the extent to which National Guard and Reserves and other components participate in and benefit from programs—such as BDD and the alternate predischARGE program—intended to expedite receipt, of VA benefits. VA agreed with this recommendation.

Lastly, we have reported on and identified a number of challenges related to efforts to achieve the long-term vision of a single “comprehensive, lifelong medical record” that would enable each servicemember to transition seamlessly between the DOD and VA. Our January 2009 report²¹ noted that while important steps have been taken, questions remained concerning when and to what extent the intended electronic sharing capabilities of the two departments will be fully achieved. We made recommendations that the departments use results-oriented performance goals and measures as the basis for future assessments and reporting of interoperability progress. The departments concurred with our recommendations.

33. Senator GRAHAM. Ms. McGinn, General Meurlin, Ms. Embrey, Admiral Timberlake, Mr. Dimsdale, and Dr. Guice, would you agree that in spite of some progress, wounded warriors and their families still need our help?

Ms. MCGINN, General MEURLIN, Ms. EMBREY, and Admiral TIMBERLAKE. We absolutely agree. Since the incidents at Walter Reed, there has been a renewed focus on wounded warriors and their families. But there is still much more to do. One area of interest that you brought up was support to family caregivers, which as we heard today is a growing priority. There is a DOD proposal to provide special monthly compensation for family caregivers paid to servicemembers who elect to participate in the expedited DES, and we are aware of at least two legislative proposals that are being initiated by Senators. It would be in the best interest of all concerned if we could examine all the proposals and capitalize on the best ideas for formal legislative action.

Mr. DIMSDALE and Dr. GUICE. The many efforts of DOD and VA are making a difference for wounded warriors and their families. From the testimony of those servicemembers and veterans on the first panel, those that had care coordination provided by the SOC coalition or the Federal recovery coordination program had an easier time navigating the systems of care provided by both departments. The many initiatives required by the NDAA 2008 legislation are in place and their effectiveness will need to be measured and tracked. Both departments are committed to identifying problems and creating durable solutions.

34. Senator GRAHAM. Ms. McGinn, General Meurlin, Ms. Embrey, Admiral Timberlake, Mr. Dimsdale, and Dr. Guice, do you agree that the pathway to obtaining needed care remains complex and difficult to navigate?

Ms. MCGINN, General MEURLIN, Ms. EMBREY, and Admiral TIMBERLAKE. In our opinion, the complexity of injuries these servicemembers experience as a result of combat make the system of care difficult to navigate, not the care itself. The particular patterns of injury require numerous specialists, frequent interfacility transfers, and lengthy periods of rehabilitation. The challenges are only increased when a family needs assistance as well. Both departments have worked hard to improve the coordination of care and benefits, rather than requiring the wounded warrior, veteran or family manage the transitions and integrate the different delivery systems alone. The development of a Clinical Case Management application via Line of Action 3, addresses the case management workflow process by coordinating collaboratively across service lines and care locations. These improvements will lead to the efficient development of collaborative relationships among servicemembers, case managers, physicians, and other medical disciplines.

Mr. DIMSDALE and Dr. GUICE. The complexity of injuries these servicemembers experience as a result of combat make the system of care difficult to navigate, not the care itself. The particular patterns of injury require numerous specialists, frequent interfacility transfers, and lengthy periods of rehabilitation. The challenges

²⁰ GAO, High-Risk Series: An Update, GAO-09-271 (Washington, DC: Jan. 22, 2009).

²¹ GAO-09-268.

are only increased when a family needs assistance as well. Both departments have worked hard to improve the coordination of care and benefits, rather than requiring the wounded warrior, veteran, or family manage the transitions and integrate the different delivery systems alone.

35. Senator GRAHAM. Ms. McGinn, General Meurlin, Ms. Embrey, Admiral Timberlake, Mr. Dimsdale, and Dr. Guice, please address the concerns that you heard and tell us what more we can expect—or we need to legislate—to achieve improvements and reform in the year ahead.

Ms. MCGINN, General MEURLIN, Ms. EMBREY, and Admiral TIMBERLAKE. A large part of what we heard today had to do with care coordination between DOD and VA—streamlining information flow and performing the hand-off from one department to the other as seamlessly as possible. The office of Transition Policy and Care Coordination in partnership with the VA is working to make these two goals a reality.

The information flow is now being managed by DOD/VA Recovery Coordinators, who, in concert with the medical and non-medical recovery teams and Services' Wounded Warrior Programs, act as the go-between for an injured servicemember, veteran, and their family with all the various case managers who now work for them.

The SOC has directed DOD and VA to identify how to implement the Virtual Electronic Lifetime Record and streamline the DES, but the work has not risen above the working group level. Once we have identified what needs to change, we will come to Congress with a more formal proposal. We want to make sure we get this right the first time.

Mr. DIMSDALE and Dr. GUICE. The testimony provided by the first panel of witnesses reminds us how important it is to “get it right.” Many more programs and resources are available today to those returning wounded or injured. It will be important to evaluate these programs and to compare the experiences of those returning today compared to those who returned in earlier years. Effectiveness should not be measured in the number of new programs or resources, but whether or not the system is improved as a result.

TRAUMATIC BRAIN INJURIES

36. Senator GRAHAM. Ms. Embrey, what is the Department's estimate of the number of veterans who have suffered brain injuries in this war?

Ms. EMBREY. As of March 31, 2009, there are 40,035 unique patients in the DOD TBI surveillance database.

37. Senator GRAHAM. Ms. Embrey, do we have sufficient resources to provide for their care?

Ms. EMBREY. Over the past 5 years, we have made tremendous headway in the care of TBI, especially for chronic symptomatic concussion, also known as mild-TBI (mTBI). There are numerous TBI clinics located at different MTFs all over the country. Additionally, ongoing education of all providers has remained a priority. Since 2007, over 800 providers per year learn how to diagnose and treat TBI through the Defense and Veterans Brain Injury (DVBIC) annual military training. DVBIC works closely with the DCoE for PH and TBI to ensure that providers treating patients with TBI have the most up-to-date scientific information available. We currently have no data to suggest insufficient resources to care for the servicemembers with TBI.

38. Senator GRAHAM. Ms. Embrey, LTC Rivas testified that his brain injury in 2006 was not diagnosed and he returned to battle. What is different for a servicemember who is injured on the battlefield today?

Ms. EMBREY. DOD has taken many steps to ensure that what happened to LTC Rivas does not happen to others. Since 2007, several task force and commission recommendations have been incorporated into the DOD TBI Action Plan. Specific advancements implemented by the DOD include, using the Military Acute Concussion Evaluation to help diagnose mTBI and clinical practice guidelines for detecting and diagnosing TBI in deployed settings. In October 2007 the DOD published additional clinical guidance for the care of mTBI in the nondeployed setting and updated it in May 2008. Also in May 2008, the DOD implemented TBI assessment questions into the post-deployment health assessment and post-deployment health reassessment to ensure there was an avenue of treatment for ongoing symptoms for all

servicemembers returning from deployment. The VA implemented similar questions in April 2007.

39. Senator GRAHAM. Ms. Embrey and Mr. Dimsdale, Congress intended that wounded servicemembers have the broadest possible options for brain injury care and rehabilitation, yet we are informed that Federal rules still limit accessible treatment options. What are the legal or bureaucratic barriers we need to address?

Ms. EMBREY. Active Duty servicemembers do have the broadest possible options for brain injury care and rehabilitation. The statutory scope of health care benefits for Active Duty servicemember is much broader than for all other categories of beneficiaries and does not limit the care to TRICARE authorized providers. There is no requirement that the care is medically or psychologically necessary, and the statute does not specifically prohibit custodial or domiciliary care. Further, reimbursement is made by using Supplemental Health Care Program (SHCP) funds to pay for the services. With the exception of benefit limitations based on Federal statute, any restrictions or limitations of the TRICARE Basic Program may be waived for Active Duty servicemembers under the SHCP in order to make available adequate healthcare services to Active Duty servicemembers or to keep or make the Active Duty servicemember fit to remain on Active Duty. Moreover, under section 1631 of the NDAA for Fiscal Year 2008, DOD may authorize Active Duty servicemember benefits for former members with a serious injury or illness if the care is not available in the VA. This authority expires December 31, 2012.

Mr. DIMSDALE. This question is specific to DOD and cannot be addressed by VA.

MEDICAL DISABILITY EVALUATIONS AND RATINGS

40. Senator GRAHAM. General Meurlin, should DOD get out of the business of evaluating and rating medical disabilities of servicemembers? If so, what needs to happen to achieve that goal?

General MEURLIN. Since the Career Compensation Act of 1949, DOD and VA have operated independent systems to examine, rate, and compensate disabled servicemembers and veterans. DOD, VA, congressional, and presidential commissions all concur on the need to eliminate dual adjudication of disability ratings by DOD and VA. On April 28, 2009, the SOC made the decision to establish a senior working group that will deliver to the SOC the vision, guiding principles, charter, and high-level options and recommendation for getting DOD to provide a "fit/unfit" finding with VA determining the disability rating and resulting compensation.

41. Senator GRAHAM. General Meurlin, has the paperwork required for medical and physical evaluation boards been reduced in the last 2 years?

General MEURLIN. The military departments have taken initiatives to reduce paperwork and evolve archaic systems. For example, the Army has an initiative for an automated physical profile system that will feed profile data to the Medical Operational Data System and the Electronic Health Record AHLTA. The Medical Evaluation Board (MEB) is also being automated, which will improve MEB case file tracking, decrease process inefficiencies, and improve data quality. The automated MEB is scheduled for testing in August 2009 at Brooke Army Medical Center, in San Antonio, TX. The system is intended to provide an automated MEB using an interface that will deliver all permanent profiles with a numerical designator of 3 or 4 directly to the MTF's MEB Physician so they may validate and initiate disability processing accordingly. Additionally, based on the SOC's guidance, we are looking at "Evolving the Disability Evaluation System", which will help facilitate additional improvements over time.

42. Senator GRAHAM. General Meurlin, have the processes been streamlined or automated?

General MEURLIN. With the introduction of the DES pilot, both DOD and VA have put in place a process that has cut the time from referral into the DES to receipt of VA benefits by approximately half. The DES pilot simplifies the process by eliminating duplicate practices of the two departments. Complementing timeliness is the integration of new case management features, such as placing VA counselors in MTFs to ensure a smooth transition for members who must move to the care of the VA. The features of the DES pilot are the result of the hard work and excellent recommendations by several commissions and task forces. These features include: servicemember-centricity; simplicity; reduction of the adversarial nature of the DES process; faster and more consistent evaluations and compensation; a single medical

exam and single-source disability rating; seamless transition to veteran status; case management advocacy; and expectation management.

43. Senator GRAHAM. General Meurlin, if a servicemember is not in the disability demonstration project—that is, the vast majority of servicemembers—what has changed since the 1940s when this archaic system was put into place?

General MEURLIN. Since the Career Compensation Act of 1949, DOD and VA have operated independent systems to examine, rate, and compensate disabled servicemembers and veterans. Both departments recognized the need to improve the current DES and stood up LOA-1. The intent was to develop and establish an integrated DOD and VA DES, one that is seamless, transparent, and administered jointly by both departments using one medical examination and one disability rating. In this regard, the department has published several policy updates to current suite of DOD regulations. In addition to the significant steps forward resulting from the DES pilot, the department has also initiated an Expedited DES, and a Physical Disability Board of Review.

In January 2009, the Department published guidance for an expedited DES process. Accelerating the process for eligible servicemembers presumed to be 100 percent disabled allows for early identification and delivery of the full range of benefits, compensation, and specialty care offered by the VA to which the servicemember may be entitled. The goal is to move the member, consistent with medical and recovery care, to permanent disability retirement so that the member may obtain benefits from the VA as soon as possible. Participation in the expedited DES process is strictly voluntary. Members who are eligible are not required to be brought to maximum medical benefit prior to receiving their disability rating and retirement disposition provided the DES process is waived.

The Secretary of Defense established a Physical Disability Board of Review (PDBR) with the Air Force as the lead agency to review disability ratings of wounded warriors, honoring the great sacrifices required of the men and women of our Armed Forces and providing another avenue of administrative recourse for our wounded veterans. Variances in disability ratings among the military departments for same or similar disorders created a perception of unfairness in applying disability ratings across the Services. Therefore, under the PDBR any servicemember may have his or her case reviewed by the PDBR if he or she was separated from the Armed Forces between September 11, 2001, and December 31, 2009. The PDBR applies to any servicemember separated due to unfitness for continued military service resulting from a physical disability under Chapter 61, Title 10 U.S.C., with a combined disability rating of 20 percent or less.

MENTAL HEALTH PROVIDERS

44. Senator GRAHAM. Ms. Embrey and Mr. Dimsdale, according to your treatment protocols, how frequently should a soldier or veteran with PTSD have face-to-face contact with a mental health provider?

Ms. EMBREY. DOD strongly encourages the use of the DOD-VA Clinical Practice Guidelines for the treatment of PTSD by providers treating servicemembers and veterans. The guideline, which was carefully developed by a team of subject matter experts from both DOD and VA, describes in great detail evidence-based assessment and treatment methodologies for use both in the primary care setting and the mental health setting. A range of treatments described in the guideline have extensive bases of support in the scientific literature, ranging from pharmacological to cognitive therapeutic interventions. While the guideline does not specify any particular frequency of face-to-face contact between patient and provider, it does reference specific treatment regimens widely known and used in the provider community.

Mr. DIMSDALE. PTSD is a condition that can have a number of different clinical courses. It can occur as a single episode, it can occur with remissions and recurrences, or it can be chronic. At any given time it could be associated with symptoms, distress, and impairments, or it could be in full or partial remission. Treatment can include pharmacotherapy, psychotherapy, and rehabilitation. The frequency of contact and decisions about face-to-face versus telemental health contacts must be individualized on the basis of a given patient's goals and needs at a given point in time.

45. Senator GRAHAM. Ms. Embrey and Mr. Dimsdale, how many more mental health providers have DOD and VA hired since 2001?

Ms. EMBREY. Mental health provider staffing (military and civilian only):

Fiscal Year 2001 - 2,010

Fiscal Year 2002 - 1,647 (-363)
 Fiscal Year 2003 - 1,643 (-3)
 Fiscal Year 2004 - 1,967 (+324)
 Fiscal Year 2005 - 1,911 (-56)
 Fiscal Year 2006 - 1,912 (+1)
 Fiscal Year 2007 - 2,530 (+618)
 Fiscal Year 2008 - 2,811 (+281)
 Fiscal Year 2009 - 3,515 (+704)

Mental health provider staffing has been on a continuous ramp-up since 2003 and we continue to increase these numbers to meet increased patient demand. Overall, since 2001, we have increased mental health providers by 1,505. Although we do not have historical information on contract mental health providers, we currently have 711 working in our MTFs.

Mr. DIMSDALE. From 2001 to 2005, VA mental health staffing was more or less stable. However, since then, staffing increased by about 5,000 full time equivalent positions from 13,950 to about 18,844 by the end of the second quarter of fiscal year 2009.

46. Senator GRAHAM. Ms. Embrey and Mr. Dimsdale, we have been told that there is a national shortage of mental health providers, is that correct? If so, are you working together on this national shortage?

Ms. EMBREY. National needs for mental health providers are developed by agencies such as the National Institute of Mental Health, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration—they have responsibilities related to mental health services throughout the United States of America.

DOD and VA are working closely on all aspects of identifying and meeting mental health staffing requirements for our wounded warriors and veterans; we have established a working partnership. DOD's mental health provider requirements are based on the needs of our wounded warriors, their families, and our beneficiaries; we are constantly adjusting these requirements.

Mr. DIMSDALE. Neither VA nor DOD can comment definitively about whether or not there is a national shortage of mental health providers. Projecting the needs for the mental health care workforce for the Nation as a whole is within the responsibilities of agencies such as the National Institute of Mental Health, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration.

VA has made major contributions toward developing the Nation's workforce in mental health. VA has long been one of the Nation's leaders in professional training for health and mental health care. With its academic affiliates, VA has been involved in graduate training in psychology and undergraduate medical education in psychiatry, as well as programs in a number of allied health professions. As a major provider of graduate medical education, VA makes a major contribution to work force development in psychiatry. Additionally, through an expanding array of VA supported internship and clinical post-doctoral fellowship positions, VA is making substantial contributions to workforce development in psychology.

Currently, the Veterans Health Administration (VHA) employs over 19,000 mental health workers. With the aid of newly-established recruitment initiatives, VA mental health staffing levels have increased by over 5,800 positions since fiscal year 2005, when VA began implementing its Mental Health Strategic Plan. Putting these figures into perspective, VA employs about 5 percent of the national pool of psychiatrists and psychologists.

With staffing as projected, VHA is able to meet the mental health care needs of the veterans it serves.

It has been VHA's experience that in certain localities, particularly highly rural regions, there is a limited number of mental health professionals, particularly psychiatrists. Specific hiring and retention incentives have been developed and used in such situations. VHA also has the flexibility to hire providers of other appropriate disciplines or to use fee-basis or contract care, when indicated, so that veterans have continuous access to the full continuum of mental health services. In addition, telemental health options are continually being expanded so that mental health professionals in areas where hiring is easier can provide services through video-conferencing to veterans in more rural sites. Through its recent efforts, VHA has developed an array of strategies to recruit and retain mental health professionals. It is currently working with DOD to share lessons learned, and to collaborate, as much as possible.

47. Senator GRAHAM. Ms. Embrey and Mr. Dimsdale, who monitors the performance of your health care systems in meeting the necessary frequency of face-to-face encounters with a mental health provider?

Ms. EMBREY. DOD maintains a range of systems and processes for ensuring the quality of mental health care for our beneficiaries. While “necessary frequency” is something that is individually developed between the patient and provider as part of the treatment planning process, the overall quality of health care provided is paramount in the ongoing evaluation process. Quality of patient care is reviewed regularly through the peer review process in each MTF, so that any issues can be detected and remedied early on. Additionally, we strongly encourage the use of the DOD-VA Clinical Practice Guidelines, including those for major depression and PTSD. Provider adherence to these evidence-based guidelines increases quality of care and enhance the likelihood of positive patient outcomes.

The DOD is planning to rollout a Behavioral Health Module as part of the electronic medical record. This module will include instruments that will be administered to our patients to measure the outcomes of their care. Frequency of sessions is less important than establishing that treatment is resulting in a positive outcome over time, whether that time is brief or over an extended period. Providers will also use this process to enhance treatment planning, and thereby facilitate positive outcomes within shorter periods of time.

The Department closely monitors access to mental health care. Having moved the 30-day standard for a first mental health appointment up to a 7-day standard, we are working to ensure that all MTFs comply with the standard. We have augmented the number of mental health professionals significantly in order to facilitate such compliance and to make mental health care more available.

Our Tricare Operations Center is able to monitor on a daily basis the number of available appointments in each clinic across the system, helping clinic managers better control patient flow and ensure the timeliness of mental health appointments.

Mr. DIMSDALE. VA uses performance metrics to monitor both access to mental health care and the continuity of mental health services. The entities with responsibility for measurement include the Office of Quality and Performance and the Office of Mental Health Services. The frequency of face-to-face encounters is based on the clinical needs of the individual.

48. Senator GRAHAM. Ms. Embrey and Mr. Dimsdale, are the resources available to meet the demand for care sufficient?

Ms. EMBREY. We have sufficient financial resources to meet our currently identified requirements associated with the demand for mental health treatment.

Two years ago, Congress authorized special pays to incentivize recruitment and retention of health care providers, including mental health care providers. We are publishing a directive-type memorandum that will provide implementation guidance to the Services for offering special pays to psychologists and social workers.

Mr. DIMSDALE. The proposed VA budget includes adequate resources to meet the mental health care needs of veterans of all eras.

CASE MANAGERS

49. Senator GRAHAM. Ms. McGinn, General Meurlin, Mr. Dimsdale, and Dr. Guice, have you ever had a conversation about the problems we have heard involving the proliferation of case managers in DOD and VA?

Ms. MCGINN and General MEURLIN. We do have numerous case managers assisting our recovering servicemembers. Both the President’s Commission on Care for America’s Returning Wounded Warriors and the NDAA 2008 recognized this and required one point of contact to oversee the recovering servicemember and family through recovery, rehab, and return to duty or reintegration into the community. This one belly button is our Recovery Care Coordinators and Federal Recovery Coordinators (FRCs). They, working with the medical and nonmedical team, will create a recovery plan for each servicemember and family with personal and professional goals that will guide them through their continuum of care. These coordinators work with the existing case/care managers to ensure the needs of our recovering servicemembers and families are met.

Mr. DIMSDALE and Dr. GUICE. There is much confusion about case management and the number of case managers. The number of clinical case managers a recovering servicemember will have is related to the types and number of their injuries and the number of facilities where care is received. Clinical case managers are critical components of a multidisciplinary team—they implement the patient’s clinical treatment plan and often serve as the link between the patient and providers. Non-

clinical case managers assist recovering servicemembers and veterans with access to programs and benefits (childcare, adaptive housing, disability determinations, et cetera). Many of these non-clinical case managers are also facility based. A recovering servicemember who requires care from three different facilities may have many case managers. Case managers generally assist the servicemember only while they are at the facility; upon transfer to another facility, the servicemember will encounter a new set of case managers.

Care coordination decreases the opportunities for confusion by providing a single point of contact and coordinator for these servicemembers and their families. Federal recovery coordinators actively coordinate the services and benefits, and work with case managers to meet recovery needs of the servicemember.

50. Senator GRAHAM. Ms. McGinn, General Meurlin, Mr. Dimsdale, and Dr. Guice, what do you plan to do about the problem expressed by our witnesses today?

Ms. MCGINN and General MEURLIN. It is our belief that past issues with multiple case managers are being resolved as the DOD Recovery Coordination Program and the DOD/VA Federal Recovery Coordination Programs continue to take hold. There are currently 147 RCCs working in 27 locations around the country through each military department's Wounded Warrior Program, and we will continue to bring more on-line during fiscal year 2009. The RCCs and FRCs are absolutely critical to identifying issues early and bringing them to resolution as soon as possible. The work that the RCCs and FRCs are doing permit the wounded, ill, or injured servicemember and their families to concentrate on their medical recovery.

Mr. DIMSDALE and Dr. GUICE. The problems articulated by the servicemembers and veterans on the first panel require thoughtful evaluation. Because so many resources and programs are now in place, a thorough understanding of their effectiveness is needed in order to better determine what remains to be addressed.

CARE FOR RETURNING SERVICEMEMBERS

51. Senator GRAHAM. Dr. Guice, you served on the staff of the Dole-Shalala Commission on care for returning servicemembers, is that correct?

Dr. GUICE. I served as the Deputy Director of the President's Commission on Care for America's Wounded Warriors, March 28, 2007–July 31, 2007. My responsibilities included providing direction for 25 researchers, managing relationships with Capitol Hill and Veteran Service Organizations, assisting Commissioners in developing recommendations and writing the final report, working with public relations to develop statements and press advisories, and assisting the Executive Director with strategic planning. I had primary responsibility for the recommendations on care coordination and rehabilitation.

52. Senator GRAHAM. Ms. McGinn, General Meurlin, Ms. Embrey, Admiral Timberlake, Mr. Dimsdale, and Dr. Guice, from your current vantage points, and based on what you have heard from our first panel, what are the biggest pieces of reform and improvement that are still needed to support seriously injured and ill servicemembers and their families?

Ms. MCGINN, General MEURLIN, Ms. EMBREY, and Admiral TIMBERLAKE. From a transition and care coordination perspective, we believe there are two problems being expressed by the previous witnesses. First, the policy, process, and provisos for getting a servicemember and their family started on the road to rehabilitation are still not streamlined enough. Specifically, Senator Nelson stated in his opening remarks that improvements are still needed in the DES, and we could not agree more. The SOC has discussed this, and we are responding by expanding the DES pilot to seven additional sites this year and we have implemented the expedited DES for those who opt to take advantage of it. Potentially combining the RCC and FRC programs may provide a more uniform approach to the servicemember and eliminate some confusion as well as requiring both the VA and DOD to come even more closely together in coordinating their care.

Second, we need to do a better job of supporting our family caregivers. This is the reason DOD has put forth the proposal for special compensation to servicemembers who participate in the expedited DES to compensate a family caregiver. Additional bills have been introduced to address this issue. The need to support caregivers is there. We need to look at all the ideas, collect the best ones, and develop the best legislative solution possible.

Mr. DIMSDALE and Dr. GUICE. Based upon the testimony of the first panel, once effective care/case management is established, it seems that the departments are meeting most of the needs of the affected servicemembers and their families. The

challenge that remains is for VA and DOD to gain a clear understanding of the effectiveness of the new programs and policies established to support seriously injured servicemembers and their families. The assessment of the new programs and policies is an ongoing activity and both departments are committed to making reforms or improvements as necessary.

53. Senator GRAHAM. Ms. McGinn, General Meurlin, Ms. Embrey, Admiral Timberlake, Mr. Dimsdale, and Dr. Guice, are the right mechanisms in place to achieve them?

Ms. MCGINN, General MEURLIN, Ms. EMBREY, and Admiral TIMBERLAKE. The DES pilot and expedited DES are in place and already helping our servicemembers and their families. We are looking to expand the pilot as quickly as possible.

For family caregivers, we will need new authority to begin a program, and look to the committee for assistance with that.

Mr. DIMSDALE and Dr. GUICE. It would appear that based upon the testimony from the first panel that the departments are clearly moving in the right direction by providing effective care and case management, while improving access to benefits and services. The establishment of new programs and policies alone does not guarantee success, but must be evaluated to ensure they are achieving their intended purpose. The Government Accountability Office (GAO) indicated in its testimony that this is something it is considering for the near future.

54. Senator GRAHAM. Ms. McGinn, General Meurlin, Ms. Embrey, Admiral Timberlake, Mr. Dimsdale, and Dr. Guice, what are the obstacles that we need to overcome?

Ms. MCGINN, General MEURLIN, Ms. EMBREY, and Admiral TIMBERLAKE. While great successes have been achieved to date, as we go forward to enhance the interoperability with the vision for the virtual lifetime electronic record agreed to by the Secretaries on March 24, the key interoperability challenges will include:

- Developing, adopting, and maturing standards at the national level to ensure efficient operational use
- Updating systems, infrastructure, and technology consistent with emerging standards
- Identifying and prioritizing information requirements as defined by the business process owners and the functional community
- Identifying, prioritizing, and implementing common services

The departments also face challenges created by: different acquisition and funding cycles; different contracting processes; and differences in information assurance certification processes for VA, DOD, DISA, the Services, and the local level.

We are working to not only identify areas where potential process differences may exist, but the departments and the IPO are collaboratively engaging in efforts to ensure that any impediment that may arise is resolved in an efficient manner.

Mr. DIMSDALE and Dr. GUICE. Since the passage of the 2008 NDAA and its wounded warrior provisions, significant progress has been made in the support provided to seriously ill and injured servicemembers, veterans, and their families. The departments remain committed to eliminating any obstacles that might prevent a truly seamless transition for the seriously ill and injured.

55. Senator GRAHAM. Ms. McGinn, General Meurlin, Ms. Embrey, Admiral Timberlake, Mr. Dimsdale, and Dr. Guice, what can Congress do to help?

Ms. MCGINN, General MEURLIN, Ms. EMBREY, and Admiral TIMBERLAKE. Congress has demonstrated its support by providing appropriate legislative authority and the resources necessary to establish and maintain the programs needed to provide for more effective care, rehabilitation, and transition for seriously ill and injured servicemembers, veterans, and their families. We look forward to working with Congress to ensure that we continue to support those who have born the burden of battle and their families.

Mr. DIMSDALE and Dr. GUICE. Congress has demonstrated its support by providing appropriate legislative authority and the resources necessary to establish and maintain the programs needed to provide for more effective care, rehabilitation, and transition for seriously ill and injured servicemembers, veterans, and their families. The departments look forward to working with Congress to ensure that we continue to support those who have born the burden of battle and their families.

QUESTIONS SUBMITTED BY SENATOR JOHN THUNE

IMPLEMENTATION OF SECTION 703

56. Senator THUNE. Ms. McGinn and Ms. Embrey, what steps has the Department taken to implement section 703 of the NDAA for Fiscal Year 2009?

Ms. MCGINN and Ms. EMBREY. A chiropractic workgroup was convened composed of senior service representatives to determine where to expand chiropractic care to best meet the needs of our Active Duty servicemembers. The results of their careful deliberations are:

Air Force

1st Special Operations Medical Group, Hurlburt Field

Army

Army Community Hospital Ft Riley
 Army Community Hospital Ft Rucker
 Army Community Hospital Ft Polk
 Army Community Hospital Ft Wainwright
 U.S. Army Medical Center Landstuhl
 U.S. Army Health Clinic Grafenwoehr

Navy

Naval Medical Clinic Quantico
 Navy Branch Health Clinic Groton
 Naval Hospital LeMoore
 U.S. Naval Hospital Okinawa

These 11 sites will bring the total number of MTFs providing chiropractic care to Active Duty servicemembers to 60. We anticipate these new sites will become operational by September 30, 2009.

57. Senator THUNE. Ms. McGinn and Ms. Embrey, has the Department found a need, due to a rise in demand for musculoskeletal services, to expand the availability of chiropractors or chiropractic services on military bases, either in the United States or overseas?

Ms. MCGINN and Ms. EMBREY. This year, we are expanding the number of MTFs that provide chiropractic care to Active Duty servicemembers from 49 locations to 60 locations. Chiropractic care is a valued treatment modality and we think that offering it at 60 locations provides a good balance.

58. Senator THUNE. Ms. McGinn and Ms. Embrey, has the Department encountered any obstacles in trying to find licensed chiropractors to be stationed at bases in the United States or overseas?

Ms. MCGINN and Ms. EMBREY. No, we have not encountered any obstacles in finding licensed chiropractors willing to work with us to care for our Active Duty servicemembers.

[Whereupon, at 5:07 p.m., the subcommittee adjourned.]

